Minutes of the meeting of the Quality and Patient Safety Committee of the Board of Directors of the Cook County Health and Hospitals System held Tuesday, December 9, 2014 at the hour of 10:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

## I. Attendance/Call to Order

Chairman Gugenheim called the meeting to order.

Present: Chairman Ada Mary Gugenheim and Director Wayne M. Lerner (2)

Board Chairman M. Hill Hammock (ex-officio) and Director Hon. Jerry Butler

Mr. Patrick T. Driscoll, Jr. (non-Director Member)

Absent: None (0)

Additional attendees and/or presenters were:

Peter Daniels – Chief Operating Officer, Hospital-Based Services
Aaron Hamb, MD – Provident Hospital of Cook County
Krishna Das, MD – System Chief Quality Officer
Aaron Hamb, MD – Provident Hospital of Cook County
Anwer Hussain, MD – Provident Hospital of Cook County
Randolph Johnston – System Associate General Counsel
Connie Mennella, MD – Cermak Health Services of Cook County
Jack Raba, MD – Cermak Health Services of Cook County
Deborah Santana – Secretary to the Board
John Jay Shannon, MD –Chief Executive Officer
David Soglin, MD – Chairman, Department of Pediatrics
Ozuru Ukoha, MD – John H. Stroger, Jr. Hospital of Cook County

## II. Public Speakers

Chairman Gugenheim asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

## III. Report from System Chief Quality Officer

### A. Regulatory and Accreditation Updates

Dr. Krishna Das, System Chief Quality Officer, provided updates on the following subjects.

#### i. College of American Pathology (CAP) Accreditation Visit

Dr. Das stated that CAP, the group that accredits the Laboratory, recently completed a two (2) day site visit. There were a series of approximately twenty (20) corrective actions resulting from the visit; there was one issue regarding training that was probably the most significant, but most were minor issues, such as typographical errors found in policies. The corrections are well underway; the administration expects to receive the full two-year accreditation for the Laboratory.

## III. Report from System Chief Quality Officer

### A. Regulatory and Accreditation Updates (continued)

#### ii. IDPH Perinatal Network Reaccreditation

Dr. David Soglin, Chairman of the Department of Pediatrics, stated that representatives from the Illinois Department of Public Health (IDPH) arrived on November 19th to survey Stroger Hospital regarding two (2) different issues: 1) status as a Level III Neonatal Intensive Care Unit (NICU); and 2) status as a Perinatal Network Hospital Center.

Dr. Soglin stated that the accreditation process went very well; three-year accreditation was received in both areas. They had two recommendations regarding the Level III NICU: 1) to enhance the breastfeeding program; and 2) to improve the ability to designate which babies in the NICU are determined to be Level III, as opposed to Level II, since only one geographic area is used. He added that the surveyors had a lot of commendations, as well, particularly in the area of high-risk follow-up for the babies that leave Stroger Hospital's NICU.

#### iii. IDPH Linear Accelerator Licensing

Dr. Das stated that representatives from IDPH recently visited to examine the new Linear Accelerator, basically for radiation safety purposes; following the visit, they granted approval of the license.

#### iv. Provident Hospital – The Joint Commission survey (Attachment #1)

Dr. Aaron Hamb, Medical Director of Provident Hospital of Cook County, and Peter Daniels, Chief Operating Officer of Hospital-Based Services, provided an overview of the information presented on the recent survey of Provident Hospital by The Joint Commission (TJC). The Committee reviewed and discussed the information.

With regard to the Condition of Participation (CoP) citation on slide 4 relating to the governing body, Board Chairman Hammock requested further clarification. Mr. Daniels responded that the governing body citation automatically comes up when there is a condition-level finding; it is removed when the condition-level finding is resolved. It requires that the resources and environment be provided to take care of the other two CoP citations within the next thirty (30) days. Director Lerner noted that if it is not resolved upon re-survey, the surveyors could ask for a meeting with the governing body to talk about issues of lack of oversight and attention to some of these details; he added that, to the extent that Provident Hospital does not meet CoP, it risks not participating in the Medicare Program, which is why it is a significant governing body issue. Dr. John Jay Shannon, Chief Executive Officer, stated that surveyors will be back for certain in January for the re-survey.

During the discussion of the second Indirect Impact Citation listed on slide 8, relating to a consultation ordered on a patient that was not completed in a timely matter, Dr. Shannon provided additional information. He stated that this issue will need to be resolved over time, as it is a long-range strategic issue. Today, two separate medical staffs exist; a Stroger Hospital-credentialed medical staff member cannot perform services for a hospitalized patient at Provident Hospital if they have not been credentialed by the Provident Hospital Medical Staff. He noted that, in the Ambulatory environment, medical staff has free range to practice at any of the sites in an Ambulatory environment.

## III. Report from System Chief Quality Officer

### A. Regulatory and Accreditation Updates

#### iv. Provident Hospital – The Joint Commission survey (continued)

Director Lerner inquired whether relationships exist with the University of Chicago for certain consultation services and/or visiting attending privileges. Dr. Hamb responded in the negative. He stated that Provident Hospital Medical Staff Bylaws allow for the opportunity for someone to have visiting attending privileges; this category is called the "affiliate" category. Management have anticipated the need for certain services and providers to be credentialed and privileged at Provident Hospital who are technically members of the Stroger Medical Staff; in those instances, those providers officially become members of the Provident Hospital Medical Staff.

Chairman Gugenheim inquired whether there is a mechanism to feed back to the hospital staff as a whole the findings presented today. Dr. Hamb responded that this is presented to a regulatory compliance committee that includes all of the key players responsible for the various different functions and chapters of TJC standards; it is then fed back to the department heads, with the expectation that they will feed it back to their staff at department-level meetings. Mr. Daniels added that, on the last day of the survey, there is an exit conference; all of the key stakeholders and participants of the survey are in attendance. Immediately after the exit conference, a department head meeting is held, and they go through the entire report.

Board Chairman Hammock noted that there are two (2) items here that the administration has appealed; he posed the following question - should those be found in Provident's favor, is there any possibility that it might trigger a recalculation of the governing body CoP citation? Mr. Daniels responded that, during this clarification period, they will double-check with them; it could resolve that aggregation.

Director Lerner inquired whether TJC requires a meeting with the governing board for the Stroger Hospital survey. Dr. Das stated that there is a leadership meeting; the organization is at liberty to define who is present at the meeting, and it has been the custom to invite Board Members to these meetings. Dr. Shannon stated that he would like to take the opportunity to thank Director Butler, who sat in on the leadership meeting at Provident Hospital; he stated that it was very helpful to see that degree of engagement there.

### B. Publicly Reported Ratings

There was nothing to report on this subject at this time.

## IV. Action Items

### A. 2015 Quality Assessment and Performance Improvement Plans:

i. **John H. Stroger, Jr. Hospital of Cook County** (Attachment #2)
ii. **Ambulatory and Community Health Network of Cook County** (Attachment #3)

Dr. Das reviewed a presentation (Attachment #4) relating to planned metrics for the Quality Plan for John H. Stroger, Jr. Hospital of Cook County (Stroger Hospital). The Committee reviewed and discussed the information.

## IV. Action Items

### A. 2015 Quality Assessment and Performance Improvement Plans (continued)

Dr. Das noted that the presentation regarding the Quality Plan for the Ambulatory and Community Health Network of Cook County was reviewed at the Quality and Patient Safety Committee Meeting in October.

In response to a question from Chairman Gugenheim regarding the information on Key Performance Indicators, Dr. Das stated that the comparison groups for all of the indicators are the entire Centers for Medicare and Medicaid Services (CMS) database. She noted that the most recent report she has received is for an eighteen month period up through the first quarter of 2014.
Director Lerner noted that most of those reporting intervals were quarterly; he asked whether those reports are generated manually or through some sort of real-time database system. Dr. Das responded that each is generated a little differently. For operating room data, there is a manual collection and an electronic collection; a freestanding Cerner report has been created to look at the turnaround times. All of the core measures use a platform called Lighthouse, which lives within Cerner; it basically involves manual abstraction with electronic support – staff has to look at the chart, but Lighthouse presents all the data needed so the abstractors do not have to dig through the details of every chart. This data is received monthly, approximately ten (10) days after the end of the month.

Director Lerner wondered if quarterly reporting is the right interval; he stated that the challenges he has found in his work was that, whether quarterly or semi-annually, he was trying to manage by looking in the rearview mirror all the time, which is difficult to do. Dr. Das stated that the internal goal is to have monthly data, because for performance improvement, a minimum of monthly data is needed to get the turnaround. She added that she is getting monthly data for almost all of these, including operating room statistics and data on core measures; the administration gets that data and reviews it every month. Director Lerner indicated that, if finance reports are available fifteen (15) days after the end of the month, and quality reports are available fifteen (15) days after the end of the month, for him, the real key is, how does the System bring quality and finance together so that one is driving the other, and the administration and Board are looking at a full menu to drive patient satisfaction?

> Director Lerner, seconded by Chairman Gugenheim, moved to approve the 2015 Quality Assessment and Performance Improvement Plans for John H. Stroger, Jr. Hospital of Cook County and the Ambulatory and Community Health Network of Cook County. THE MOTION CARRIED UNANIMOUSLY.

### B. Minutes of the Quality and Patient Safety Committee Meeting, October 28, 2014

> Director Lerner, seconded by Chairman Gugenheim, moved to accept the Minutes of the Quality and Patient Safety Committee Meeting of October 28, 2014. THE MOTION CARRIED UNANIMOUSLY.

### C. **Medical Staff Appointments/Re-appointments/Changes** (Attachment #5)

> Director Lerner, seconded by Chairman Gugenheim, moved to approve the Medical Staff Appointments/Reappointments/Changes. THE MOTION CARRIED UNANIMOUSLY.

### D. Any items listed under Sections IV, V and VI

## V. Recommendations, Discussion/Information Items

### A. Reports from the Medical Staff Executive Committees

#### i. Provident Hospital of Cook County

#### ii. John H. Stroger, Jr. Hospital of Cook County

Dr. Anwer Hussain, President of the Executive Medical Staff (EMS) of Provident Hospital of Cook County, presented his report. He thanked all of those involved in the preparations for the survey by The Joint Commission. With regard to the System's Flu Policy, he stated that he was pleased to report that 100% of the Medical Staff at Provident Hospital are compliant with the policy.

Dr. Hussain provided additional information regarding sub-specialty care, which was discussed earlier in the meeting. Currently, when a patient at Provident Hospital requires sub-specialty care that is not available at Provident Hospital, staff makes the necessary phone calls to the person on-call at Stroger Hospital to make the appropriate transfer. He stated that there are very good communications between the Medical Staffs at Provident and Stroger Hospitals.

Dr. Ozuru Ukoha, President of the EMS of John H. Stroger, Jr. Hospital of Cook County, presented his report, which included information on the following subjects.

Dr. Ukoha surmised that there may be a mass exodus of doctors from this institution due to issues relating to pension reform. For many years the System has brought doctors into this institution and paid them less than market price, on the promise that the difference would be made up by having a terrific pension plan. Most of these doctors have poured their blood, sweat and tears into this institution for many years; now they are potentially going to reach the precipice and make a decision about their future. The overall effect of this group of doctors leaving cannot be underestimated.

Dr. Ukoha stated that, when deciding whether to join an institution, in addition to compensation issues, doctors look at the patient mix of the institution. He stated that doctors want patients as complex as possible. The System's patients have suddenly become hot commodities around the City; this is likely going to affect the patient mix here. Stroger Hospital is judged every year by its trainees; if it goes through one cycle of bad presentation to the trainees, the quality of applicants to the institution will drop.

Dr. Ukoha described issues experienced with the Patient Portal. He stated that the message has been communicated to the patients very clearly to make sure their doctor is on their health plan. The Medical Staff was very concerned when the Patient Portal did not reflect this information for over three months; it either had the wrong information or was not complete enough.

Dr. Ukoha described issues with having the right tools and resources to effectively care for patients. He referenced the inability in some areas to get state of the art equipment that could affect the System's ability to offer the most attractive treatment options for patients. Some of the issues involve delays with getting basic fundamental medical supplies due to process issues.

Dr. Shannon stated that a number of the sentiments and concerns Dr. Ukoha raised are legitimate; the System has very significant problems that need to be addressed to make sure it has the right care, right tools, and right people available at the right time. There are plans to put a number of these pieces in place, but there is a sense of time urgency, so pieces will have to be prioritized; the most important thing that Dr. Ukoha pointed out is the issue of being able to have the right environment, resources and tools necessary for the medical staff to do what they need to do with the patients who walk in the door.

## V. Recommendations, Discussion/Information Items

### A. Reports from the Medical Staff Executive Committees (continued)

Dr. Shannon stated that, as an organization, the administration will have to figure out when and how to adopt new technologies. Some of them are just more expensive and fancier, and some of them have measurable improvements in care; he believes that staff needs to engage in the analysis to determine when those are in the latter category.

Director Butler stated that what is most pressing is how the System will track its patients and redeterminations. Director Lerner noted that the Board has a new committee regarding CountyCare; as far as he is concerned, the CountyCare focus has to be one of the highest priorities right now, because those are the patients that everyone wants.

## VI. Closed Meeting Items

**A. Medical Staff Appointments/Re-appointments/Changes**
**B. Litigation Matter(s)**
**C. Cermak Update**

Director Lerner, seconded by Chairman Gugenheim, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," 5 ILCS 120/2(c)(**11**), regarding "litigation, when an action against, affecting or on behalf of the particular body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting," and 5 ILCS 120/2(c)(**17**), regarding "the recruitment, credentialing, discipline or formal peer review of physicians or other health care professionals for a hospital, or other institution providing medical care, that is operated by the public body."

On the motion to recess the open meeting and convene into a closed meeting, a roll call was taken, the votes of yeas and nays being as follows:

Yeas: Chairman Gugenheim and Director Lerner (2)

Nays: None (0)

Absent: None (0)

THE MOTION CARRIED UNANIMOUSLY.

Chairman Gugenheim declared that the closed meeting was adjourned. The Committee reconvened into the open meeting.

## VII. Adjourn

As the agenda was exhausted, Chairman Gugenheim declared that the meeting was ADJOURNED.

Respectfully submitted,
Quality and Patient Safety Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXX
Ada Mary Gugenheim, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

# Joint Commission Survey Overview:

## Provident Hospital of Cook County

### Report of the Medical Director

CCHHS Board of Directors

Quality and Patient Safety Committee

12.9.2014

# Survey Summary

- 'Deemed status' survey for CMS; every 3 years
- 3 days, 2 surveyors (+ 1 in training)
  - Life Safety Surveyor – Field Director for Life Safety Code Surveyors/Engineers at TJC.
  - Field Surveyor – 16 years experience as Joint Commission surveyor
- Process:
  - Tracers- arrive in clinical area and request to review a specific patient
    - Medical Surgical Unit, Perioperative Area and Sterile Processing, Emergency Department
  - Document review: files of employees identified in tracers, chart review
  - Conference + documents: Leadership, Emergency Management, Data Management , Medical Staff Credentialing
- Positive comments:
  - Involvement and knowledge of clinical staff, esp. navigation of the eHR
  - Leadership hospitality and commitment
  - Excellent credentialing files
- Citations listed below– 'direct impact' and 'indirect impact'

# Summary of Citations

| Type of Citation | Number of Citations | Significance of Citation |
|---|---|---|
| Condition of Participation | 3 | Items found out of compliance with external regulations requiring immediate correction and resurvey in 30 days (new). |
| Direct Impact | 2 | May directly impact accreditation. Requires ESC (evidence of standards compliance) in 45 days. (Due date: 1/8/2015) |
| Indirect Impact | 10 | Does not directly impact on accreditation. Requires ESC in 60 days. (Due date: 1/23/2015) |
| Opportunity for Improvement | 10 | Single items noted within a particular standard. Informational to the institution (new). |

# Conditions of Participation (CoP)

| Description | Specifics | Plan |
|---|---|---|
| Compliance with federal, state and local laws | Compliance expected with the Global Harmonizing System (new OSHA requirement for labeling hazardous material) as of 12/2013 | **Conduct** training to meet current requirements; plan full conversion across CCHHS to be completed by 2016 (full compliance expected) |
| Physical environment | Aggregate of all Environment of Care (EC) and Life Safety (LS) citations | **Correct** designated EC and LS citations (8) |
| Governing body | Auto scoring assigns a citation for the Leadership standard when any other condition level citations are given. | **Correct** all condition level citations |

# Direct Impact Citations

| Description of the Standard | Specifics | Plan |
|---|---|---|
| EC.02.05.01Hospital manages risks associated with its utility systems | Circuit breakers in the electrical closet were labeled as "spares" when they were in use.<br>Decontamination area should have a negative air flow. | **Apply** appropriate labels to circuit breakers.<br><br>Corrected during survey |
| LS.02.01.20 Hospital maintains the integrity of the means of egress | In one area of the hospital the appropriate exit signage was not present and visible to staff and patients to designate multiple means of evacuation in case of an emergency; some doors were locked | **Implement** appropriate signage and in interim remove locks on doors while patients are present |

# Indirect Impact

| Description of the Standard | Specifics | Plan |
|---|---|---|
| EC.02.02.01 Management of hazardous materials and waste | No comprehensive risk assessment has been completed related to the presence of certain chemical agents | **Complete** comprehensive risk assessment. |
| EC.02.03.01 Management of fire risks | Written fire response plan does not specifically address the role of licensed independent practitioners. | **Revise** fire plan to address the role of licensed independent practitioners. |
| EC.02.03.03 Hospital conducts fire drills | Critique of fire drills did not include evaluation of the visual alarm features of the system. | **Revise policy and evaluation tool** to include evaluation of the visual alarms. |
| EC.02.03.05 Maintain fire equipment and fire safety building features | Failure to document notification of off-site responders while testing of the fire alarm equipment. | **Implement process** of fire department (CFD) confirmation of notification during quarterly fire drills. |

# Indirect Impact

| Description of the Standard | Specifics | Plan |
|---|---|---|
| EC.02.06.01 Establish and maintain a safe, functional environment | Pressure relationship not appropriate for 3 soiled and clean utility rooms relative to the corridor. Establish physical separation of full and empty 02 tanks. | **Corrected during survey** |
| LD.01.03.01 Governing body is accountable for safety and quality of care, treatment and services. | Automatically scored as non-compliant due to several EC and LS issues identified(new) | **Correct** the 2 citations for CMS CoP |
| LD.04.01.01 Compliance with law and regulations | Compliance expected with the Global Harmonizing System (new OSHA requirement for labeling hazardous material) as of 12/2013 | **Conduct** training to meet current requirements; plan full conversion across CCHHS to be completed by 2016 |

# Indirect Impact

| Description of the Standard | Specifics | Plan |
|---|---|---|
| LS.02.01.70 Maintenance of operating features that conform to fire and smoke prevention | One container > 32 gallons in place and two 32 gallon containers located side-by-side. | **Separate/remove** containers; apply for waiver for containers as appropriate. |
| MS.03.01.01 Medical staff oversees the quality of patient care, treatment, and services by practitioners | Consultation ordered on a patient not completed in timely manner. | **Re-education** of unit staff to escalate reminders for consults; **re-education** of providers to cancel orders that are no longer applicable. |
| PC.01.02.01 Assessment and reassessment of patients | Nutritional screening criteria are not applied consistently and per policy. | **Revise** dietary screening criteria – dietary, nursing and medical staff; update relevant policies |

# Opportunities for Improvement

- J box cover missing
- Specify year of NFPA (National Fire Protection Association) standard used for testing and inspection
- Update human resource files and qualifications of staff to current job description
- Clarify process of orientation of CCDOC officers to hospital setting
- Appropriate fire stop materials within conduit
- Missing sprinkler escutcheon
- Cable lying on approved automatic sprinkler system
- 28 day labeling of insulin vials once opened
- Update Broselow Tape in ED (chart indicating appropriate pediatric drug dosing)
- Documentation of pre and post treatment assessment with HHN treatments.

# Response Plan

- Each response is detailed: **WHO, WHAT, WHEN, HOW**
- Distribute response templates with details
- Identify process owner for each response
- Insist on a multidisciplinary approach
- Data collection plans required for specific citations to be incorporated into Quality Indicators for 2015 where appropriate.
- Preliminary response due in-house Friday, 12/5/2014
- Final submission due to TJC 1/8/2015 (for 45 day) and 1/23/2015 (for 60 day)

ATTACHMENT #2

# CCHHS John H. Stroger Jr. Hospital Quality Assessment and Performance Improvement Plan

# 2015

**John H. Stroger, Jr. Hospital Quality Plan**
**Outline**

I. Introduction

II. Background, Scope and Purpose

III. Governance and Leadership
- a. Role of the Governing Board
- b. Role of the Executive Medical Staff
- c. Role of the Hospitals Quality Committees
- d. Role of the Quality Department and the Chief Quality Officer

IV. Transparency

V. Patient Safety
- a. Adverse and Sentinel Events
- b. Event Awareness and Notification
- c. Evaluation of Adverse and Sentinel Events
  - i. Referral for Evaluation
  - ii. Root Cause Analysis
  - iii. Just Culture
- d. Event Resolution and Action Plans
- e. Proactive Risk Assessments
  - i. Medical Staff Committees Which Measure and Improve Patient Safety
    - (a) Blood Bank Committee
    - (b) Cancer Committee
    - (c) Critical Care and Resuscitation Committees
    - (d) Drug and Formulary and Drug Use Evaluation Committees
    - (e) Environment of Care Committee
    - (f) Infection Control Committee
    - (g) Operating Room Committee
    - (h) Surgical Function Review Committee
  - ii. Failure Modes and Effects Analysis
  - iii. Priority Patient Safety Projects
- f. Culture of Safety
  - i. Assessment
  - ii. Intervention

VI. Patient Complaints and Patient Satisfaction

VII. Quality Metrics
- a. Description
- b. Data Abstraction
- c. Performance Targets

# John H. Stroger, Jr. Hospital of CCHHS
# Quality Assessment and Performance Improvement Plan 2015

I. **Purpose:** The Mission of the Cook County Health and Hospitals System (CCHHS) is to provide a comprehensive program of quality healthcare, with respect and dignity, to all residents of Cook County, regardless of their ability to pay. To support this mission, the System develops a Quality Assessment and Performance Improvement Plan for each affiliate, to specify the approach to quality improvement and to enunciate achievement targets for performance improvement, and to assure approval of the plan by the leaders of the organization including the Board of Directors and the Executive Medical Staff. The purpose of this document is to set forth the Quality Assessment and Performance Improvement Plan for John H. Stroger, Jr. ('Stroger') Hospital for FY 2015.

II. **Background and Scope:** A comprehensive quality improvement plan supports the Cook County Health and Hospitals System's and John H. Stroger, Jr. Hospital's goals to provide excellent, high quality patient care and outlines the specific mechanisms to achieve this goal. The plan is a requirement under the Conditions of Participation of the Centers for Medicare & Medicaid Services (CMS) (**APPENDIX A)** and fulfills specific requirements of The Joint Commission (**APPENDIX B and APPENDIX C)**, the accrediting organization for the Hospital and the Health System. The plan is designed to be approved by the governing body of CCHHS which is the Board of Directors, upon the recommendation of its committee on Quality and Patient Safety, and upon approval by the Executive Medical Staff of Stroger Hospital and System Leadership. By approving the plan, the Board of Directors, the System Leadership and the Executive Medical Staff are:

a. Overseeing the quality and patient safety activities within the organization
b. Ensuring that the organization takes a proactive approach to planning for patient safety and quality patient care
c. Ensuring that an integrated safety program exists within the organization
d. Setting priorities for performance improvement, evaluating the performance improvement practices in the organization and ensuring that performance improvement strategies and methodologies are implemented throughout the organization
e. Ensuring data collection and monitoring in diverse areas as specified below
f. Ensuring that the hospital analyzes and compares the data it collects using statistical techniques and that data and other information are used systematically for decision making.

This plan reflects institutional patient safety and quality priorities for FY 2014 for Stroger Hospital. The written plan allows the hospital's Executive Medical Staff and the Board of Directors to ensure that the program reflects the complexity of the hospital's organization and services and involves all departments and services. The plan enumerates quality indicators and together with the Patient Safety Plan, describes the hospital's process to prevent and reduce medical errors. This plan provides direction for a hospital-wide, data driven quality assessment and performance improvement program.

The structure of the Quality Assessment and Performance Improvement Plan is derived from the Triple Aim enunciated by the national quality strategy within the Affordable Care Act. This directs health care providers to improve the care for individuals, assess and improve the care of populations and to lower per capita costs in health care. In addition, as outlined by the Institute of Medicine Report, '*To Err is Human*', quality improvement efforts in health care should ensure that patient care is safe, timely, effective, efficient, equitable and patient centered. Stroger Hospital is committed to addressing all of these dimensions of quality within the Quality Improvement plan.

At Stroger Hospital, quality assessment and performance improvement functions are divided into three major domains. Thus the Quality Improvement plan is divided into sections to address each of the following:

a. *Patient safety* involves the recognition, assessment and mitigation of serious safety events including sentinel events. For details on targeted metrics refer to the Stroger Hospital Patient Safety plan.
b. *Quality assessment* and reporting of quality metrics include the 'core measures' or process measures required for reporting to CMS and the Joint Commission; outcome measures such as mortality, readmission rates, and rates of hospital acquired conditions; and measures of patient satisfaction with care.
c. *Performance improvement* efforts focus on high risk, high volume activities and problem prone areas and set specific performance targets for these areas. Performance improvement projects may arise from tracking medical errors and adverse patient events which require corrective actions for risk mitigation. Interdisciplinary processes are used for performance improvement as described below. After implementing improvement projects, the performance is tracked over time to assess the sustainability of improvement efforts.

III. **Governance and Leadership:** Oversight of the quality plan for Stroger Hospital is provided by its governing body, the Board of Directors; by the medical staff through its elected representatives, the Executive Medical Staff Committee; and by the leadership of CCHHS. The plan is to be approved by Hospital Quality Improvement and Patient Safety Committee; by the Executive Medical Staff Committee of the Hospital; and by the Quality and Patient Safety Committee and the Board of Directors of the CCHHS. Quality and patient safety metrics are reported regularly as part of a quality and safety dashboard to the Executive Medical Staff and the Board of Directors in the same manner as described in **APPENDIX D.**

Implementation of the Quality Plan is the responsibility of the Department of Quality and Patient Safety led by the Chief Quality Officer and executed in collaboration with departmental quality committees, hospital and system leadership and the System Departments of Risk Management, Legal, and Compliance.

The Hospital Quality Improvement and Patient Safety Committee serves the dual function of oversight of the Quality Program as well as the Patient Safety Program. The composition and leadership of this committee is presented in **APPENDIX E**. This committee meets monthly and reviews all quality metrics, departmental and committee quality data, patient safety data and prioritizes performance improvement projects. The committee chair or

designee reports the activities of the committee to the Executive Medical Staff on a monthly basis and the Medical Staff approves the minutes and activities of the committee prior to presentation to the Board of Directors.

IV. **Transparency:** CCHHS is committed to transparency in the abstraction and reporting of quality metrics. These metrics, together with the performance targets set by the leadership, are to be disseminated widely among leadership and staff and will be available for viewing internally on the CCHHS website.

V. **Patient Safety Program:** The Stroger Hospital Quality Improvement and Patient Safety Committee ('Quality Committee') is the multidisciplinary committee (**APPENDIX E**) which provides guidance and leadership for the Hospital's patient safety program under the Director of Patient Safety (who serves as the hospital's Patient Safety Officer). The Quality Committee receives reports from medical staff committees as well as summary reports from the Hospital Oversight Committee and the Patient Safety Council. The Quality Committee determines the priorities for corrective action plans or performance improvement projects arising from the evaluation of such events as well as patient safety hazards identified by the medical staff committees which assess such risks. More detail can be found in the hospital's Patient Safety Plan.

a. *Adverse and Sentinel Events:* The definition, reporting and evaluation of adverse events are dictated by regulation and hospital policy. The initial reporting process is outlined in **APPENDIX F**. All significant events are evaluated by departmental and/or hospital wide oversight committees. Root cause analyses are performed for all significant safety events as defined by hospital policy and the Joint Commission (**APPENDIX G**). Other serious adverse events are defined by the National Quality Foundation (**APPENDIX H**). The results of investigations and recommendations for performance improvement are presented to the Quality Committee which prioritizes performance improvement activities and monitors progress toward the achievement of the plans. The results of the evaluation of such events are reported to the hospital leadership and the Executive Medical Staff.

b. *Event Awareness and Notification:* Adverse events may be reported using a variety of systems.
    i. Electronic event reporting system: For Stroger Hospital the UHC Safety Intelligence © electronic reporting system is used and known locally as eMERS. This system also functions as a PSO (patient safety organization), and the events reported into this system have protection from disclosure in litigation; this feature allows honest and timely reporting which supports efforts to evaluate and mitigate potential risks.
    ii. Phone calls: confidential phone reports may be made by care providers to the Quality Improvement/Patient Safety department (phone line: 4-SAFE or 4-7233), to Risk Management, or to the Executive Medical Director. These reports are also entered into the event reporting system by quality and risk and this allows tracking of all reported events.

iii. Departmental reports: Medical and Nursing departments have internal review processes to assess the quality of care provided by members of the respective department. This includes oversight activities, case conferences, mortality and morbidity reviews, reviews performed for OPPE or FPPE (ongoing or focused professional practice evaluation), or evaluations conducted by the Medical Staff Peer Review Committee.

iv. Referrals from outside agencies: Although rare, events may be identified during review by the QIO (Quality Improvement Organization) affiliated with the hospital, or by state or national regulators (IDPH; Illinois Department of Public Health, CMS; Centers for Medicare & Medicaid Services, The Joint Commission).

All of the above events, regardless of the method of identification, are reported internally as described in **APPENDIX F** and evaluated as described below.

c. *Evaluation of Adverse and Sentinel Events:* The management of adverse and sentinel events is described in hospital policy. Serious events are evaluated expeditiously and thoroughly with a goal to understand the contributory factors and to mitigate the risk to of future events.

d. *Just Culture and Accountability:* Stroger Hospital uses a 'Just Culture' approach to determine the level of individual accountability for adverse events. The focus is on system factors but if there is an issue of individual accountability it will be referred to the management of that individual's department as appropriate.

e. *Event Resolution and Action Plans:* The RCA should identify a series of changes in systems and processes to reduce the risk of recurrence of similar and should result in an action plan. The action plan will identify the person(s) responsible for the implementation of the plan, and define measures of success for the plan. Responsibility for monitoring the effectiveness of the action plan is delegated to the Quality Committee.

f. *Proactive Risk Assessments*: Stroger Hospital conducts proactive risk assessments in several high risk areas. Some of these assessments are conducted by the Medical Staff committees which evaluate specific clinical processes, as listed below (also, **APPENDIX J**). One high risk process is selected annually for an in-depth analysis of risk points utilizing the methods of failure modes and effects analysis (FMEA). Several additional high-risk, high-volume areas are targeted by the hospital for special projects in FY 2015 and these are described below.

i. Medical Staff Committees: Medical Staff committees are required to collect and report data related to high-risk processes in patient care. These committees define priorities for process improvement and engage in improvement activities as described below; these are reported to the Quality Committee.

1. Blood Bank Committee: collects data on the appropriateness of the use of blood and blood products and on all reported and confirmed transfusion reactions.

2. Cancer Committee: reports results of cancer prevention, and psychosocial assessment of cancer patients.
3. Critical Care and Resuscitation Committees: the Critical Care committee collects data on diverse indicators related to intensive care. FY 2015 priorities for this committee include monitoring restraint prevalence and process, and improving the reporting of resuscitation results.
4. Drug and Formulary and Drug Use Evaluation Committees: In FY 2015 this committee will review appropriate utilization of medical therapy.
5. Environment of Care committee: Evaluates environmental and life safety hazards, monitors the response to product safety and device alerts and recalls, and provides oversight of the Emergency Response Plan.
6. Infection Control Committee: Priorities for this committee for FY 2015 include reducing the risks of catheter associated urinary tract infections and monitoring and improving compliance with hand hygiene.
7. Operating Room Committee: works collaboratively with the Departments of Surgery, Anesthesia and Nursing to enforce use of surgical checklists and time outs and improve OR throughput.
8. Surgical Function Review Committee: a high priority for FY 2015 is to improve the timeliness of reporting of serious pathology results.

ii. FMEA, or Failure Modes and Effects Analysis: This is a multidisciplinary process which utilizes process mapping, identifies potential failure modes and examines the impact of these failure modes on patient care. A risk scoring system is used for identifying and evaluating improvement opportunities. Stroger Hospital has selected the process of preparing and treating a patient in the operating room as a candidate for FMEA for FY 2015.

iii. Priority Patient Safety Projects: Stroger Hospital has prioritized three high-risk, high-volume clinical processes for robust multidisciplinary process improvement initiatives in FY 2015. Further details are available in the Hospital's Patient Safety Plan. These are described below:
1. Adverse Drug Events (ADEs): These events will be tracked and monitored using the eMERS system. An ADE workgroup will be convened through the patient safety council to review the causes of ADEs and to complete performance improvement projects.
2. Hospital Acquired Infections: CLABSI (central line associated blood stream infections) and CAUTI (catheter associated urinary tract infections) are both preventable with the use of infection control best practices and standard checklists. A subgroup will be chartered through the patient safety council to improve the hospital's performance in these areas using proven strategies and a team based approach.
3. Hospital Acquired Conditions: Patient falls and hospital acquired pressure ulcers (HAPU) are sources of morbidity for hospitalized patients and may also impact on the cost of care. Best practices have been described for the prevention and mitigation of these hazards. The

nursing teams in collaboration with quality staff are applying these best practices in a systematic fashion to reduce the risk of these hospital acquired conditions among patients at Stroger Hospital.

*g.* **Culture of Safety**: Stroger Hospital is taking steps to improve the culture of safety in the organization. Culture reflects the beliefs and attitudes of the hospital's staffs, and is measured using a validated survey. Positive safety cultures are associated with increased reporting of adverse events and staff involvement in strengthening patient safety efforts.

i. *Assessment:* A safety culture survey, which is an assessment tool (validated by AHRQ and administered by a third party) will be administered at all CCHHS affiliates and is analyzed using national benchmark data. The next survey will be performed in the Winter of 2015.

ii. *Interventions*: Several interventions are planned to enhance the culture of safety at CCHHS. These include:

1. Leadership walk rounds: allows leaders to directly communicate safety priorities, support reporting behaviors and to hear staff concerns.
2. Interdisciplinary rounds: allow robust interdisciplinary planning of patient care, including pain management, infection prevention and discharge planning; these utilize a structured format and are led by unit based staff.
3. Unit based safety programs: these provide opportunities for all staff to participate in quality improvement programs.

VI. **Patient Complaints and Patient Satisfaction:** Patient feedback and perceptions of the safety and quality of care are vitally important to the development of a responsive, patient centered organization. Stroger Hospital welcomes feedback, comments and complaints from patients and recognizes that patients and their families have the right to have complaints reviewed by the hospital. An established complaint resolution process implemented by the Office of Patient Relations receives, prioritizes and responds to all complaints from patients. Serious consideration is given to every complaint, and hospital policy is established regarding timeliness of resolution. These processes are designed not only to enhance patient satisfaction but to also identify conditions which may impact on patient safety.

Structured surveys of selected samples of discharged patients are administered by an independent organization and the results are reported to hospital leadership. This type of feedback from patients is used to restructure processes to support patient safety, communication and patient education.

VII. **Quality Metrics:** Quality measures are collected and reported to monitor and enhance quality of care; to report to the federal state and county governments; for legal and regulatory purposes and to support reimbursement and pay for performance initiatives. This section describes the metrics, the methods of abstraction and performance targets for FY 2015.

a. *Description of Metrics:* Under the inpatient quality reporting (IQR) program of CMS the metrics reported in **APPENDIX L, M** are abstracted and reported on a quarterly basis to CMS. A subset of these measures is reported to the Joint Commission. These measures are reported publicly on the site Hospital Compare and constitute a significant portion of the CCHHS quality dashboard.
   i. Process Measures: Evidence based process measures reflect good clinical practice and high levels of achievement in these areas correlate with good patient outcomes. These processes include stroke care, preventive interventions in all patients to reduce the incidence of thromboembolism in the hospital, to administer influenza vaccination and to properly care for surgical patients (**APPENDIX L**). The hospital's performance in these areas is used to determine the priorities for performance improvement projects.
   ii. Outcome Measures - Mortality and Readmissions: CMS uses administrative data to calculate overall mortality, readmission rates to the hospital and rates of hospital acquired conditions.
   iii. Outcome Measures- Hospital Acquired Conditions: Hospital acquired infections represent a major, and preventable, source of morbidity in the hospital (**APPENDIX M**). In addition, a variety of hospital acquired complications are abstracted from hospital claims and reported publicly.
   iv. Outcome Measures – Emergency Department(ED) Throughput: Wait times in the ED are monitored. ED wait times reflect hospital throughput and a hospital wide capacity management.

b. *Data Abstraction:* CCHHS uses computer supported data abstraction through the electronic medical record (EMR) system for the majority of IQR process measures. Cases are sampled using logic in the abstraction program (denominator) and there are links to the EHR to support manual abstraction. Numerator data are assessed case by case by the abstractor and compliance is measured as a percentage. Data is abstracted monthly for all process measures but is reported quarterly; reporting to the Joint Commission occurs concurrently with CMS reporting. Data submission is through a third party. Data for outcome measures may be abstracted by hospital abstractors (ED data), or reported to CMS via standard channels (infection control data is first reported to the Centers for Disease Control through NHSN) or abstracted by CMS directly from its claims database (mortality, readmissions and hospital acquired conditions).

c. *Performance Targets:* These are determined by the type of data (process or outcome) and by indicator. A subset of process measures have been selected for the Hospital's and System's quality priorities for FY 2015 (see below). Performance targets are set at a higher threshold for these metrics, to the top decile (or > $90^{th}$ %ile) of achievement. One set of outcome measures, OR throughput, has also been selected as a quality priority (see below). For all other measures, the achievement target for FY 2014 is above median performance (> $50^{th}$ %ile).

VIII. **System Quality Priorities/ Stroger Hospital Quality Priorities:** The Hospital quality priorities are to improve access to care, demonstrate excellence in the delivery of care and to improve patient satisfaction. These priorities are divided into Inpatient and Nursing priorities, listed

in **APPENDIX I** and discussed below**. APPENDIX I** also displays the baseline and target performance for each indicator. The baseline measurement is Q3 of 2014 and achievement will be assessed in Q3 of 2015. Data on progress toward the targets will be reported quarterly to the Board of Directors.

a. *Inpatient:* Delays in OR (operating room) start times and in room turnover in the OR may result in delays, inefficiencies and a lack of OR capacity to serve our patients. A comprehensive program to improve OR throughput is planned for FY 2015 and the OR Committee (a committee of the medical staff) has been tasked with this performance improvement project. The targets for performance improvement in this area are aggressive and reflect best practices. The key quality indicators also reflect goals in prevention – the use of thromboprophylaxis to decrease rates of hospital acquired thromboembolic events and the rate of influenza vaccination of inpatients. The target for these process measures is top decile performance. These aggressive goals will require comprehensive multidisciplinary efforts including nursing, administration and medical staff. Patient satisfaction with hospital care is reflected in the summary measure of 'willingness to recommend the hospital'.

b. *Nursing Sensitive Indicators:* Nursing sensitive indicators include fall rates and hospital acquired pressure ulcer rates. Accurate data collection systems are in place for these indicators and target performance is reduction of these outcomes by 25%. The nursing indicator of communication with patients reflects the hospital's goal to provide excellent customer service and to enhance patient satisfaction.

c. *Role of Medical Staff in Achieving Quality Priorities*: The department chairs and medical staff are responsible to the Executive Medical Staff Committee and the Quality Committee for maintaining a consistently high level of patient care. Each department has identified quality priorities which support the institutional goals as outlined above and has selected high priority indicators for regular reporting to the Quality Committee. These indicators are listed by department in **APPENDIX K**.

IX. **Data Acquisition and Analysis:** The hospital collects data in a variety of settings to support the quality enterprise. The Board of Directors along with System Leadership and the Executive Medical Staff set the priorities for data collection as well as the frequency of data collection. The Board of Directors assures adequate resources to accomplish data acquisition and analyses required for the quality program. The priorities and requirements for data collection for FY 2015 are summarized in the tables in **APPENDICES I, J, K**. Data is compared to external benchmarks whenever these are available and the significance of the comparison is evaluated using statistical techniques. Data is displayed using run charts which show the evolution of performance over time and is correlated with performance improvement initiatives. The data may be assessed using statistical process control techniques which can differentiate between special and common causes of variation; this information will be used to describe the nature of performance improvement initiatives which can best address variation. The goal is to achieve high reliability in quality measures.

X. **Performance Improvement:** Priorities for performance improvement are established by the organizations leadership, which includes the Quality Committee, Executive Medical Staff, System Leadership and the Board of Directors. High-risk, high-volume or problem prone areas are prioritized for performance improvement projects after consideration of the incidence, prevalence and severity of problems in these areas and whether these problems are known to affect health outcomes, patient safety and quality of care. Performance improvement projects are proportional to the scope and complexity of the hospital's services, as outlined in **APPENDICES I, J and K**.

The hospital's approach to performance improvement projects is in a transitional phase from P-D-C-A to a Lean/Six Sigma Approach. This choice reflects the emphasis on value in health care operations and the alignment of Lean concepts with value and the reduction of waste. This approach accurately reflects the multidisciplinary nature of health care and the processes under study. The Lean approach also supports the possibility of rapid cycle performance improvement which may be used in selected cases, particularly in unit based improvement programs. Six Sigma addresses the variation in quality measurement which reflects the stability of the process under study.

Performance improvement projects will address variation by designing high-reliability interventions which are known to create sustained changes. This includes system redesign, forcing functions, checks and redundancies and consideration of human factors. High reliability organizations are characterized by sensitivity to operations, reluctance to simplify, a preoccupation with failure, deference to expertise and resilience. Monitoring of performance improvement activities will be provided by the hospital Quality Committee. Staff in the Department of Quality and Patient Safety will process data required for performance improvement projects and provide facilitation for these projects as required.

**XI.** **Confidentiality**: All information, data, reports, minutes or memoranda relating to the implementation of this Quality Assessment and Performance Improvement Plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving patient care. As such, they are strictly confidential under the Illinois Medical Studies and Hospital Licensing Act. The confidentiality of patient specific data will be protected in observance of HIPAA regulations and aggregated, de-identified data will be used whenever possible for quality data reporting.

## APPENDIX A
## CMS (Centers for Medicare and Medicaid Services) Regulations Guiding Quality Plans

**Regulation (CFR 482.21 sections A-0263 - A-0267):**

The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services, involves all hospital departments and services (including those services furnished under contract or arrangement), and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

**(a)Standard: Program Scope**

i. The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.
ii. The hospital must measure, analyze, and track quality indicators, including adverse patient events and other aspects of performance that assess processes of care, hospital service and operations.

**(b)Standard: Program Data**

(1) The program must incorporate quality indicator data including patient care data and other relevant data, eg information submitted to or received from the hospital's Quality Improvement Organization.
(2) The hospital must use the data collected to (i) monitor the effectiveness and safety of services and quality of care and (ii) identify opportunities for improvement and changes that will lead to improvement.
(3) The frequency and detail of data collection must be specified by the hospital's governing body.

**(c)Standard: Program Activities**

(1) The hospital must set priorities for its performance improvement activities that: (i) focus on high-risk, high-volume, or problem-prone areas; (ii) consider the incidence, prevalence, and severity of problems in those

areas and (iii) affect health outcomes, patient safety and quality of care.
(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.
(3) The hospital must take actions aimed at performance improvement and after implementing those actions the hospital must measure its success and track performance to ensure that improvements are sustained.

**(d)Standard: Performance Improvement Projects**
As part of its quality assessment and performance improvement program the hospital must conduct performance improvement projects.

(1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations.
(2) A hospital may.. develop and implement an information technology system explicitly designed to improve patient safety and quality of care.
(3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects and the measurable progress achieved on these projects.

**(e)Standard: Executive Responsibilities**
The hospital's governing body, medical staff, and administrative officials are responsible and accountable for ensuring the following:

(1) That an ongoing program for quality improvement, and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
(2) That the hospital-wide quality assessment and quality improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated.
(3) That clear expectations for safety are established.
(4) That adequate resources are allocated for measuring, assessing, improving and sustaining the hospital performance and reducing risk to patients.
(5) The determination of projects is conducted annually

## APPENDIX B:
## Joint Commission Leadership Standards

**LD.01.03.01**
The governing body is ultimately accountable for the safety and quality of care, treatment and services. The governing body defines in writing its responsibilities

**LD.02.03.01**
The governing body, senior manager and leaders of the organized medical staff regularly communicate with each other on issues of safety and quality. Leaders discuss issues that affect the hospital and the population it serves, including performance improvement activities, reported safety and quality issues, proposed solutions and their impact on resources, reports on key quality measures and safety indicators, safety and quality issues specific to the population served.

**LD.03.01.01**
Leaders create and maintain a culture of safety throughout the hospital. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools and prioritize and implement changes identified by the evaluation.

**LD.03.02.01**
The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

**LD.03.05.01**
Leaders implement changes in existing processes to improve the performance of the hospital. Structures for managing change and performance improvement exist. The hospital has a systematic approach to change and performance improvement. Leaders provide resources required for performance improvement and change management.

**LD.04.04.01**
Leaders establish priorities for performance improvement; set priorities for performance improvement activities and patient health outcomes, and give priority to high-volume, high-risk or problem prone processes for performance improvement activities.

**LD.04.04.03**
New or modified services and processes are designed incorporating multiple factors (i.e. patient/staff needs, results of quality activities, information about patient risks, and sentinel event information)

**LD.04.04.05**
The hospital has an organization-wide, integrated patient safety program within its performance improvement activities. The leaders implement a hospital-wide patient safety program. One or more qualified individuals or an interdisciplinary group manages the safety program. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors to hazardous conditions and sentinel events. All departments, programs and services within the hospital participate in the safety program.

## APPENDIX C:
## Joint Commission Performance Improvement Standards

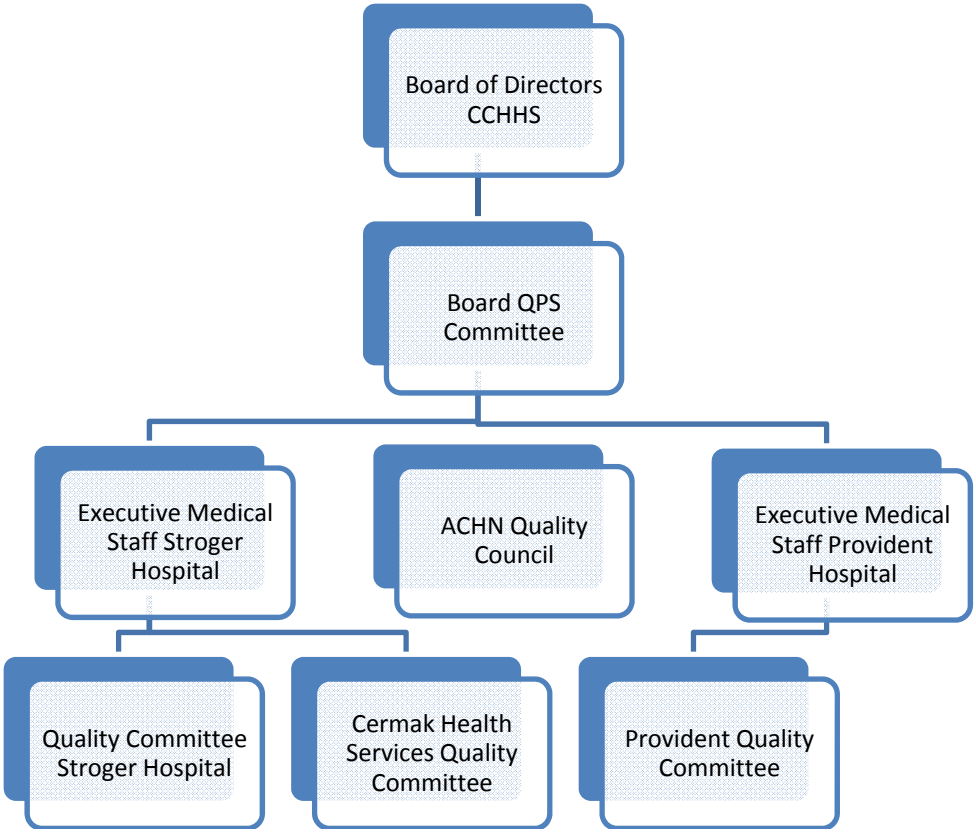
**PI.01.01.01, EP 1-8, 11, 12, 14-16, 30, 38**
The hospital collects data to monitor its performance. Leaders set priorities for data collection. The leaders identify the frequency for data collection. The hospital collects data on

- the performance improvement priorities identified by leaders
- operative and other procedures that place the patient at risk of disability or death
- all significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- adverse events related to using moderate or deep sedation
- use of blood and blood components
- all reported and confirmed transfusion reactions
- results of resuscitation
- behavior management and treatment
- significant medication errors
- significant adverse drug reactions
- patient perception of the safety and quality of care, treatment, and services
- effectiveness of fall reduction activities
- effectiveness of response to change or deterioration in a patient's condition

**PI.02.01.01, EP 1-8**
The hospital compiles and analyzes data. The hospital compiles data in usable formats, identifies the frequency for data analysis, uses statistical tools and techniques to analyze and display the data, analyzes and compares internal data over time to identify levels of performance, patterns, trends and variations, and compares data with external sources, when available.

**PI.03.01.01, EP 1-4**
The hospital improves performance on an ongoing basis. Leaders prioritize the identified improvement opportunities. The hospital takes action on improvement priorities. The hospital evaluates actions to confirm that they resulted in improvements.

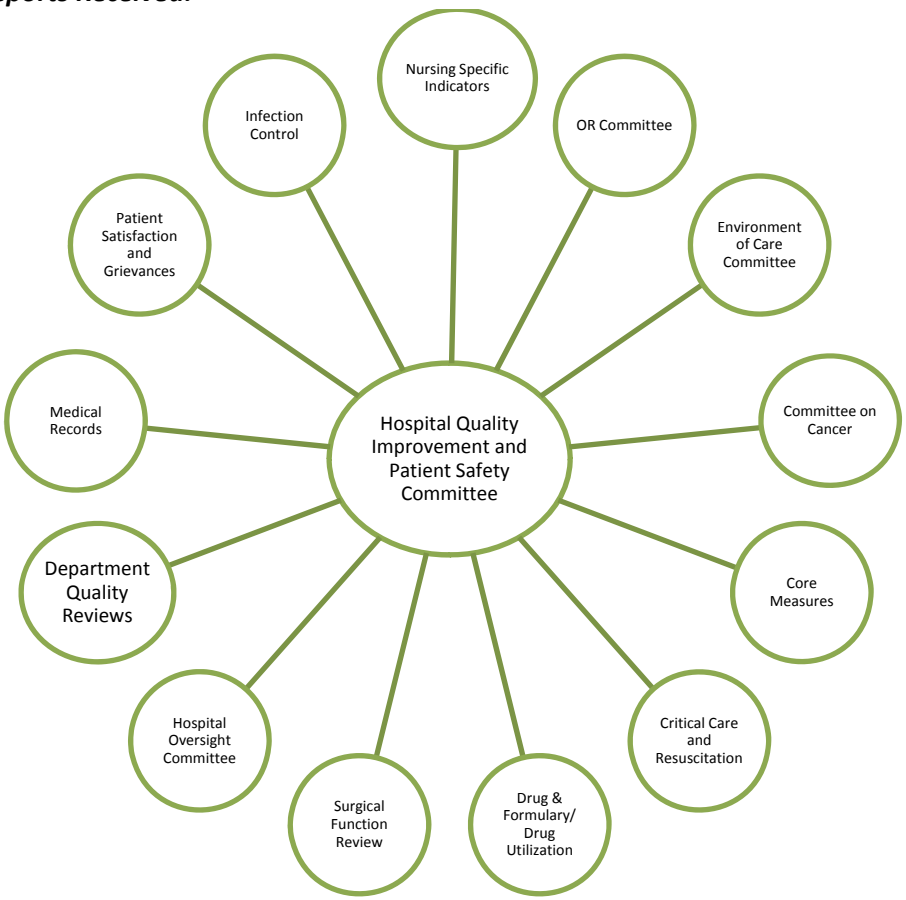
**APPENDIX D:**
**CCHHS Quality Reporting Overview**




*Reports to the Board may be provided by the Chief Operating Officer for Hospital Based Services or by the Chief Quality Officer or the Executive Medical Director

## APPENDIX E:
## Hospital Wide Quality Improvement and Patient Safety Committee Description

***Committee Reports Received:***



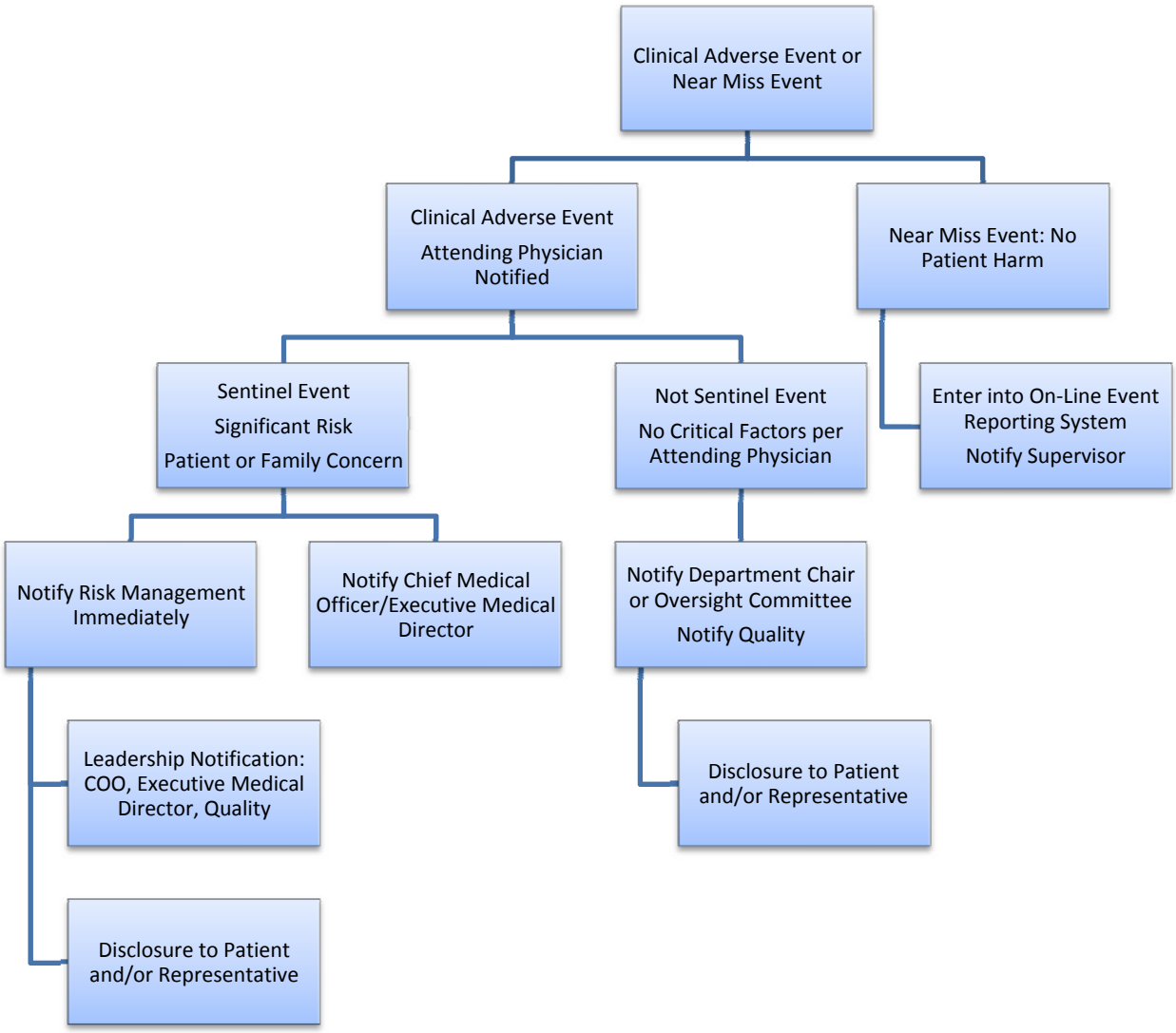

Committee Membership:

Committee Chair and Vice Chair
President, Executive Medical Staff
Medical Department Chairs
Executive Medical Director (System)
Chief Quality Officer (System)
COO Hospital Based Services
COO Ambulatory Services
Chief Nursing Officer (Stroger Hospital)
Chief Financial Officer (Stroger Hospital)
Director of Supply Chain Management (System)
Chief Clinical Informatics Officer
Director of Health Information (System)
Director of Patient Experience (System)
Director of Pharmacy (System)
Director of Infection Control (System)

*Ex Officio*

Chair, Quality and Patient Safety Subcommittee, CCHHS Board of Directors
Executive Director of Nursing
Director of Multicultural Affairs
Chief Financial Officer (System)
CMIO (System)
Quality Staff

**APPENDIX F:**
**Recognition and Reporting of Adverse Events**



## APPENDIX G:
## Sentinel Events (Joint Commission)

The event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition§ ||

**or**

1. The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition):
2. Suicide of any patient receiving care, treatment and services in a staffed around the-clock care setting or within 72 hours of discharge
3. Unanticipated death of a full-term infant Abduction of any patient receiving care, treatment, and services
4. Discharge of an infant to the wrong family
5. Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services#
6. Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization
7. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
8. Invasive procedure, including surgery, on the wrong patient, wrong site, or wrong procedure**
9. Unintended retention of a foreign object in a patient after surgery or other invasive procedures
10. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
11. Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

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§A distinction is made between an adverse outcome that is primarily related to the natural course of the patient's illness or underlying condition (not reviewed under the Sentinel Event Policy) and a death or major permanent loss of function that is associated with the treatment (including "recognized complications") or lack of treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient's illness or underlying condition (reviewable under the Sentinel Event Policy). In indeterminate cases, the event will be presumed reviewable and the hospital's response will be reviewed under the Sentinel Event Policy according to the prescribed procedures and time frames without delay for additional information such as autopsy results.

||*Major permanent loss of function* means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change. When major permanent loss of function cannot be immediately determined, applicability of the policy is not established until either the patient is discharged with continued major loss of function or two weeks have elapsed with persistent major loss of function, whichever is the longer period.

#*Sexual abuse/assault (including rape),* as a reviewable sentinel event, is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine reviewability:

n Any staff-witnessed sexual contact as described above

n Admission by the perpetrator that sexual contact, as described above, occurred on the premises

n Sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact

## APPENDIX H:
## Never Events (National Quality Foundation)

### Surgical or Invasive Procedures

1A. Surgery or other invasive procedure performed on the wrong site
1B. Surgery or other invasive procedure performed on the wrong patient
1C. Wrong surgical or other invasive procedure performed on a patient
1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient

### Product or Device Events

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

### Patient Protection Events

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
3B. Patient death or serious injury associated with patient elopement (disappearance)
3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

### Care Management Events

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
4B. Patient death or serious injury associated with unsafe administration of blood products
4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting
4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
4G. Artificial insemination with the wrong donor sperm or wrong egg
4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

## APPENDIX H, cont'd:
## Never Events (National Quality Foundation)

### Environmental Events

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

### Radiologic Events

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area

### Potential Criminal Events

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
7B. Abduction of a patient/resident of any age
7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
7D. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

**APPENDIX I**
**Key Performance Indicators – Inpatient Services**

| Hospital Indicator[1] | Baseline Q3 2014 | Target | 50th %ile[2] | 90th %ile | Reporting Interval |
|---|---|---|---|---|---|
| Operating Room: OR on-time starts (%) | 37 | 80 | 64 | 88 | Quarterly |
| Operating Room: OR room turnaround time (minutes) | 51 min | 35 min | 29 | 23 | Quarterly |
| Core Measure: VTE Prophylaxis General Care | 91 | 99 | 88 | 99 | Quarterly |
| Prevention: Influenza Vaccination | 75 | 90 | 93 | 100 | Quarterly |
| Patient Satisfaction: Recommend the Hospital | 67 | 84.7 | 72.4 | 84.7 | Quarterly |
| **Nursing Indicator** | **Baseline Q3 2014** | **Target** | **50th %ile** | **90th %ile *** | **Reporting Interval** |
| Patient Satisfaction: Communication with Nurses is 'good' | 69 | 85.7 | 79.5 | 85.7 | Quarterly |
| Fall rate/ falls with injury | 0.6 | 25% reduction | - | - | Quarterly |
| Hospital Acquired Pressure Ulcers (HAPU) | 0.6 | 25% reduction | - | - | Quarterly |

**APPENDIX J:**
**Medical Staff Committees Quality and Safety Indicators**

| Committee | Indicators | | | Data Source | Reporting Frequency |
|---|---|---|---|---|---|
| Blood Bank & Transfusion | Transfusion Reactions | Red Cells -- Appropriate | Platelets -- Appropriate | Chart review | Semiannual |
| Cancer Committee | Quality project - prevention | Registry Report | Psychosocial Evaluation | Abstraction Chart Review | Semiannual |
| Critical Care & Resuscitation | Ventilator complication rate | Restraint prevalence & complications | Resuscitation Results | Inf Control data Nursing review GWTG data | Semiannual |
| Drug Usage Evaluation | # ADRs reported monthly | Allergy alerts overridden by user | Drug-lab alerts overridden | Incident Reporting system; Cerner | Annual |
| Environment of Care | Fire Safety | Integrity Fire Doors | Completion of EOC Rounds | EOC rounds | Semiannual |
| Infection Control | CAUTI rate | CLABSI rate | Handwashing Compliance | Infection control dept | Semiannual |
| Medical Education | Medication reconciliation performed | Enunciate knowledge re DC safety | Satisfaction with doctors | Cerner HCAHPS Survey | Annual |
| Medical Information | DC summary completed 30 d | Operative notes completed | Admission H&P signed 48 hours | Cerner reports | Quarterly |
| Nursing Quality | HAPU report | Fall report | Patient Experience Nursing | Surveys Chart review Cerner reports | Quarterly |
| Operating Room | Use of time outs | Room TAT | On time starts | Chart reviews Incident reports | Quarterly |
| Patient Safety Council | eMERS Summary | Monthly Patient Safety Events | Time from Last Sentinel Event | eMERS Chart review | Quarterly |
| Surgical Function Review | Discrepancies pre and post op diagnoses | % Malignant Path reported in 7 days | % PAP smears F/U in one month | Lab system reports | Quarterly |

**APPENDIX K:**
**Departmental Quality Indicators**

| Department | Indicators | Data Source(s) | Frequency |
|---|---|---|---|
| Anesthesia | • Use of WHO check list<br>• Handoff to PACU staff<br>• Moderate sedation assessment | Cerner Lighthouse<br>Cerner IView | Quarterly |
| Correctional Health | • Grievance response times<br>• Nurse request reviewed in 24 hours | Local Abstraction | Semiannual |
| Emergency Med | • Registration to provider (outpatient)<br>• Registration to admission (inpatient)<br>• Time to treatment long bone fractures | Cerner Lighthouse | Quarterly |
| Family Med | • VTE prophylaxis -- inpatients<br>• Influenza vaccine – inpatients<br>• Influenza vaccine – outpatients<br>• Patients with appt 14 days post discharge | Lighthouse<br>Cerner reports | Quarterly |
| Internal Med | • VTE prophylaxis -- inpatients<br>• Influenza vaccine – inpatients<br>• Influenza vaccine – outpatients<br>• Patients with appt 14 days post discharge | Lighthouse<br>Cerner reports | Quarterly |
| Obstetrics/ Gynecology | • Caesarean section rate<br>• Elective delivery 37-39 weeks<br>• Breast feeding initiation<br>• Skin to skin contact time | OB database | Quarterly |
| Oral Health | • Chart review compliance<br>• Adverse event review | Chart review | Semiannual |
| Pathology | • TAT CBC and PT/PTT for ED<br>• TAT blood product delivery to Provident<br>• Inpatient early morning draw refusal rate<br>• Critical results reported -- inpatient | Lab system | Quarterly |
| Pediatrics | • Mortality in v. low birth weight infants<br>• Pediatric immunization rates<br>• Appropriate asthma care | VON network<br>CMApp<br>Cerner | Quarterly |
| Psychiatry | • Outpatient clinic show rates<br>• Post natal depression screen<br>• Lab ordering and results follow-up | Chart review | Quarterly |

| | | | |
|---|---|---|---|
| Radiology | • TAT Emergency Studies: Arch and Ectopic<br>• Contrast: abdominal CT<br>• Contrast: thoracic CT | Cerner<br>PACS data | Quarterly |
| Surgery | • SCIP: glucose control<br>• Intraoperative deaths/ 30 day mortality<br>• Unplanned Re-operation within 7 days | Cerner<br>Lighthouse<br>Cerner reports | Quarterly |
| Trauma | • Time to from Resus to Operating room<br>• Negative laparotomy rate<br>• Time from Resus to Burn ICU | Chart review<br>Cerner | Quarterly |

**APPENDIX L**
**CMS Inpatient Quality Reporting (IQR) Indicators – 2015**

| Measure | Abstracted | Allow EHR | EHR only |
|---|---|---|---|
| **AMI – Myocardial infarction** | | | |
| AMI-2 Aspirin prescribed at discharge | | | X |
| AMI-7a Fibrinolytic within 30 minutes | X | X | |
| *AMI-8a Timing of primary PCI* | | | X |
| AMI-10 Statin prescribed at discharge | | | X |
| **ED-- Emergency Dept Throughput** | | | |
| ED-1 ED arrival to departure time; admitted pts. | X | X | |
| ED-2 ED admit decision to ED departure time | X | X | |
| **PN – Pneumonia** | | | |
| *PN-6 Appropriate initial antibiotic selection* | | | X |
| **IMM – Immunization** | | | |
| IMM-2 Influenza vaccination | X | - | - |
| **SCIP—Surgical Care** | | | |
| *SCIP Inf-1 Antibiotics in 1 hr prior to incision* | | | X |
| *SCIP Inf-2 Appropriate selection of antibiotics* | | | X |
| SCIP Inf-4 Post-op glucose control | X | | - |
| *SCIP Inf-9 Urinary catheter removal* | | | X |
| **STK – Stroke Measures** | | | |
| STK-1 VTE prophylaxis | X | | - |
| *STK-2 Discharge on antithrombotic therapy* | | | X |
| *STK-3 Anticoagulation for Afib* | | | X |
| STK-4 Thrombolytic therapy for stroke | X | X | |
| *STK-5 Antithrombotic by day 2* | | | X |
| STK-6 Statin therapy at discharge | X | X | |
| STK-8 Stroke education | X | X | |
| *STK-10 Assess for rehabilitation* | | | X |
| **VTE – Prevention of Thromboembolic Events** | | | |
| VTE-1 VTE prophylaxis | X | X | |
| VTE-2 VTE prophylaxis in ICU | X | X | |
| VTE-3 Overlap therapy | X | X | |
| *VTE-4 Heparin therapy per protocol* | | | X |
| VTE-5 Warfarin discharge instructions | X | X | |
| VTE-6 Potentially avoidable VTE | X | X | |
| **PC – Perinatal Care** | | | |
| PC-01 Early elective delivery | X | X | |
| PC-05 Breast milk feeding | | X | |
| **Other Reported Measures*** | | | |
| Hospital Acquired Infections (NHSN) | | | |
| Patient Experience (HCAHPS) | | | |
| Mortality measures (CMS Claims) | | | |
| Readmission measures (CMS Claims) | | | |

*** see Appendix M for details. Measures in italics are optional**

**Appendix M**
**Hospital Acquired Conditions – 2015**

| Condition | Data Source |
|---|---|
| **PSI-90 Hospital and Surgical Complications** | |
| PSI-03 Pressure Ulcers | Claims |
| PSI-06 Iatrogenic Pneumothorax | Claims |
| PSI-07 Central Venous Line Infections | Claims |
| PSI-08 Post-op Hip Fracture | Claims |
| PSI-12 Post-op Venous Thromboembolism | Claims |
| PSI-13 Post-op Sepsis | Claims |
| PSI-14 Post-op Wound Dehiscence | Claims |
| PSI-15 Accidental Puncture or Laceration | Claims |
| | |
| **HAI- Hospital Acquired Infections** | |
| Central Line Associated Blood Stream Infections | NHSN |
| Surgical Site Infections | NHSN |
| Catheter Associated Urinary Tract Infections | NHSN |
| MRSA Bacteremia | NHSN |
| C Difficile Associated Disease | NHSN |
| Influenza Vaccination of Healthcare Workers | Local/NHSN |
| | |

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ATTACHMENT #3

# CCHHS Ambulatory Services Quality Assessment and Performance Improvement Plan

# 2015

## Strategy

I. Introduction

II. Background, Scope and Purpose

III. Governance and Leadership
- a. Role of the Governing Board and Medical Leadership
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IV. Transparency

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VI. Patient Safety
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  - i. Referral for Evaluation
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- d. Event Resolution and Action Plans
- e. Proactive Risk Assessments
  - i. Quality Committees Which Measure and Improve Patient Safety
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    - (b) Nursing Council
    - (c) Affiliate Infection Control Committee
    - (d) Affiliate Environment of Care Committee
  - ii. Priorities Patient Safety Projects
- f. Culture of Safety
  - i. Assessment
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VII. Patient Complaints and Patient Satisfaction

VIII. Quality Metrics
- a. Alignment with System Priorities
- b. Description
- c. Metric selection
- d. Data Sources
  - i. HEDIS
  - ii. EMR
  - iii. CMApp
- e. Data Acquisition and Analysis

**I. Introduction:**

The Ambulatory and Community Health Network's (ACHN) mission is to deliver integrated health services with dignity and respect, regardless of a patient's ability to pay; to foster partnerships with other health care providers and communities in order to enhance the health of the public; and to advocate for policies which promote and protect the physical, mental and social wellbeing of the people of Cook County. Our vision is to provide accessible high quality comprehensive primary, preventative, coordinated specialty care and diagnostic services, utilizing a patient centered team based model of care.

**Goals:**

(1) Integrate all patients into a Primary Care Medical Home and attach them to a Primary Care Provider of their choice.
(2) Actively engage patients and their families in their care and self-management.
(3) Organize evidenced-based patient care across all elements of the broader health system.
(4) Promote continuity in transitions of care from internal and external services.

The purpose of this document is to set forth the Quality Assessment and Performance Improvement Plan for the Ambulatory & Community Health Network for FY 2015. The plan aligns with the mission of the Cook County Health and Hospitals System (CCHHS), to provide a comprehensive program of quality healthcare with respect and dignity, to all residents of Cook County, regardless of their ability to pay. The approach to quality improvement is to enunciate achievement targets for performance improvement, and to assure approval of the plan by the leaders of the organization including the Board of Directors and the Executive Medical Staff.

**II. Background and Scope:** The Ambulatory & Community Health Network is committed to the delivery of high quality patient care and sets forth a comprehensive quality improvement plan, which aligns with the United States National Quality Strategy, to improve the quality of care, reduce costs and improve health outcomes for patients serviced. The Joint Commission and CMS do not require organizations that solely provide Ambulatory non-surgical care to have a formal quality plan in place. At the same time, this plan supports the Cook County Health and Hospitals System's goal to provide excellent, high quality patient care and outlines the specific mechanisms to achieve this objective.

The Ambulatory Quality Improvement Plan is designed to be approved by the governing body of CCHHS which is the Board of Directors, upon the recommendation of its committee on Quality and Patient Safety after the approval by the Quality Council of ACHN and System Leadership. By approving the plan, the Board of Directors, the System Leadership and the ACHN Quality Council are:

- Overseeing the quality and patient safety activities within Ambulatory
- Ensuring that the organization takes a proactive approach to planning for patient safety and quality patient care
- Ensuring that an integrated safety program exists within the organization
- Setting priorities for performance improvement, evaluating the performance improvement practices in the organization and ensuring that performance

improvement strategies and methodologies are implemented throughout the organization
- Ensuring data collection and monitoring in diverse areas as specified below
- Ensuring that ACHN analyzes and compares the data it collects using statistical techniques and that data and other information are used systematically for decision making.

The structure of the Quality Assessment and Performance Improvement Plan is derived from the Triple Aim enunciated by the national quality strategy within the Affordable Care Act. This directs health care providers to improve the care for individuals, assess and improve the care of populations and to lower per capita costs in health care. As outlined by the Institute of Medicine Report '*To Err is Human*', quality improvement efforts in health care should ensure that patient care is safe, timely, effective, efficient, equitable and patient centered. CCHHS and the Ambulatory & Community Health Network are committed to addressing all of these dimensions of quality within the Quality Improvement Plan.

This plan reflects the ACHN patient safety and quality priorities for FY 2015. The plan enumerates the indicators related to health outcomes and describes the ACHN's process to prevent and reduce medical errors. The Ambulatory & Community Health Network quality assessment and performance improvement functions are divided into three major domains. Thus the Quality Improvement plan is divided into sections to address each of the following:

a. *Patient safety*: Involves monitoring of Meaningful Use documentation, the recognition, assessment and mitigation of adverse patient events, including sentinel events, and involves retroactive as well as proactive risk assessment.
b. *Quality assessment* and reporting of quality metrics: Includes Meaningful Use measures, physician quality reporting system or 'PQRS' measures and measures of patient satisfaction with care.
c. *Performance improvement* efforts: Focus on high risk, high volume activities and problem prone areas and set specific performance targets for these areas. Interdisciplinary processes are used for performance improvement as described below. After implementing improvement projects, the performance is tracked over time to assess the sustainability of improvement efforts.

**III. Governance and Leadership:** Oversight of the quality plan for ACHN is provided by the Board of Directors, Board Quality and Patient Safety Committee, the Executive Medical Staff, and by the Executive Leadership of CCHHS.

**a.** Role of the Governing Board and Medical Leadership:
The plan is approved by the ACHN Quality Council and is approved by the Quality and Patient Safety Committee and the Board of Directors of CCHHS. The plan is shared with the Medical Staff of affiliated hospitals. Results of patient safety assessments, quality metrics and results of performance improvement projects are also reported to the Medical Staffs and the Board of Directors in the same manner as described in **APPENDIX C.**

**b.** Role of the Quality Director and Chief Quality Offic**er:**
Implementation of the Quality Plan is the responsibility of the ACHN Department of Quality and Accreditation led by the Ambulatory Quality Director under the direction of the Chief Quality Officer and executed in collaboration with the ACHN Quality Council, System Leadership and the system departments of Risk Management, Legal, and Compliance.

**c.** Role of the Quality Council**:**
The ACHN Quality Council serves the dual function of oversight of the Quality Program as well as the Patient Safety Program. The composition and leadership of this committee is presented in **APPENDIX D**. This Council meets monthly and reviews all quality metrics and patient safety events, and prioritizes performance improvement projects. The Council chair or designee reports the activities of the committee to the Executive Medical Staff on a monthly basis.

**IV. Transparency:** CCHHS and ACHN are committed to transparency in the abstraction and reporting of quality metrics. These metrics, together with the performance targets set by the leadership, are to be disseminated widely among leadership and staff, and will be available for viewing internally on the CCHHS website.

**V. Primary Care Medical Home (PCMH):** The Ambulatory and Community Health Network is committed to the implementation of the PCMH model of care in primary care sites, and seeks to obtain the Joint Commission Primary Care Medical Home (PCMH) certification during FY 2015. A description of the core functions of the Medical Home is contained in **APPENDIX I**. This certification also supports the new federal health care reform strategy which is to improve health outcomes, continuity, quality and efficiency of health care services. The goal of the certification process is to evaluate how effectively a primary care provider and interdisciplinary team work in partnership with the patient and their family. This patient-centric approach is encouraged and benefits patients by increased access to the primary care providers and their care team. Patient care is more efficiently tracked, coordinated and health information technology features are used to support care. There is more patient involvement in the development of the treatment plan and a more significant role in the self-management of their care. Current PCMH improvement efforts include the launching of focused workgroups to oversee the implementation in these key areas: patient information, referral tracking, performance improvement, health literacy, patient access and primary care provider choice. Staff and patient education regarding Medical Home functions are also important components of PCMH sustainability efforts.

**VI. Patient Safety Program:** The ACHN Quality Council is the multidisciplinary group (**APPENDIX D**) which provides guidance and leadership for ACHN's patient safety program. The Quality Council receives reports of adverse and sentinel event and determines the priorities for corrective action plans, performance improvement projects arising from the evaluation of such events and patient safety hazards identified.

**a.** *Adverse and Sentinel Events:* The definition, reporting and evaluation of adverse events are dictated by regulation and ACHN policy. The initial reporting process is

outlined in **APPENDIX E**. All significant events are evaluated by departments and the Quality Council. Root cause analyses are performed for all sentinel events as defined by CCHHS policy and the Joint Commission (**APPENDIX F**). The results of investigations and recommendations for performance improvement are presented to the Quality Council which prioritizes performance improvement activities and monitors progress toward the achievement.

**b.** *Event Awareness and Notification:* Adverse events may be reported using a variety of systems.

i. Electronic event reporting system: electronic reporting systems such as eMERS, function within a PSO (patient safety organization). This feature allows honest and timely reporting which supports efforts to evaluate and mitigate potential risks.
ii. Phone calls: confidential phone reports may be made by care providers to the Quality Improvement/Patient Safety department, to Risk Management, or to the Executive Medical Director. These reports are also entered into the event reporting system by quality and risk which permits tracking of all reported events.
iii. Departmental reports: medical departments and the Nursing council will have internal review processes to assess the quality of care provided by members of their respective disciplines. This includes oversight activities, case conferences, mortality and morbidity reviews, and reviews performed for OPPE or FPPE (ongoing or focused professional practice evaluation).
iv. Referrals from outside agencies: although rare, events may be identified during review by state or national regulators (IDPH; Illinois Department of Public Health, Centers for Medicare & Medicaid Services, The Joint Commission) or from litigation filed.

All of the above events regardless of the method of identification are reported internally as described in **APPENDIX E** and evaluated as described below.

**c.** *Evaluation of Adverse and Sentinel Events:* The management of adverse and sentinel events is described in ACHN policy. These serious events are evaluated expeditiously and thoroughly with a goal to understand contributory factors to mitigate risks and prevent future occurrences.

i. Referral for Evaluation: all reported adverse events are reviewed by Quality and Patient safety staff to determine the severity of the event and the urgency of evaluation. ACHN is committed to performing a timely, thorough and credible root cause analysis (RCA) on all sentinel events and 'Serious Reportable Events' as well as all adverse events which do not fit either criteria but are deemed to require further investigation.
ii. Root Cause Analysis: the root cause analysis includes participation by appropriate ACHN leadership and the individuals most closely involved with the event or systems which contributed to the event. The framework for the RCA is the one developed by the Joint Commission which focuses on systems and not individuals.

iii. Just Culture and Accountability: ACHN uses a 'just culture' approach to determine the level of individual accountability for adverse events. The focus is on system factors and individual accountability when appropriate

**d.** *Event Resolution and Action Plans:* The RCA should identify systems changes to reduce the risk of recurrence of similar events which should result in an action plan. The action plan will identify the person(s) responsible for the implementation of the plan and define measures of success for it. Responsibility for monitoring the effectiveness of the action plan is delegated to the Quality Council.

**e.** *Proactive Risk Assessments*: ACHN conducts proactive risk assessments in several high risk areas. High-risk, high-volume areas are targeted by ACHN for special projects in FY 2015 and these are described below.

i. Quality committees which measure and improve patient safety: These committees are required to collect and report data related to high-risk processes in patient care. These committees define priorities for process improvement and engage in improvement activities.
   a. Laboratory Committee: The laboratory committee provides oversight of laboratory practices and protocols to encourage uniformity, addresses laboratory issues and concerns affecting patient care delivery and quality of care.
   b. Nursing Council: This group of nursing leaders oversees nursing practice and conduct internal review processes to assess the quality of care provided by members of nursing and other adjunct disciplines.
   c. Infection Control Committee: The priorities for this committee for FY 2015 include improving compliance with hand hygiene and patient and employee influenza vaccination.
   d. Environment of Care committee: This committee monitors environmental and life safety hazards which include oversight of the emergency response plan for product safety, device alerts and recalls.

ii. Priority Patient Safety Projects: ACHN has prioritized four high-risk, high-volume clinical processes for robust multidisciplinary process improvement initiatives. These are described below:
   a. Transitions in Care: The discharge from the ED and inpatient setting is a particularly vulnerable time for patients, especially when there are limited financial, family and social resources available. The likelihood of readmission to hospitals, repeated ED visits, duplication of services is prevalent when patients are not reconnected with their primary care providers and/or health care teams. To optimize the safety of the discharge transition, in FY 2015 ACHN seeks to enhance the in-reach and out-reach efforts for patients in collaboration with CCHHS and other hospitals in Chicago and the surrounding suburban areas. The reinforcement of follow-up compliance with PCP's and interdisciplinary teams is messaged

to patients. This will be monitored with the measurement of compliance with post hospital and ED discharge follow-up within 14 days and tracked.

b. Learning Needs Assessment: Learning barriers impact patients' overall health status. Every individual has their own preference in how they receive new information. It is essential to identify barriers to improve patient learning and identify learning preferences to help optimize educational encounters. ACHN developed and launched a Learning Needs screening tool in May 2015 to determine the learning and health literacy needs of its patient population. Interventions will be based on the findings.

c. Patient and Employee Influenza Vaccination compliance: Influenza is a highly contagious and unpredictable virus that can result in serious illness and death, and can cause disease in all age groups. Vaccination is the most effective way to decrease transmission to patients and others. ACHN supports the CCHHS Employee Influenza vaccination program and has developed an EMR decision support driven patient vaccination program. Patient influenza vaccination surveillance data will be displayed internally in monthly system-wide informational briefs for all locations.

d. Accurately Identifying patients**:** Patient errors can occur in all stages of diagnosis, services and treatment due to not reliably identifying patients. Using at least two identifiers is essential to preventing these types of errors. ACHN continues to monitor the use of name and birth date identifiers at all point of service through observational audits of staff and the review of medical record entries.

**f.** Culture of Safety: ACHN is taking steps to improve the culture of safety in the organization. Culture reflects the beliefs and attitudes of ACHN staffs, and is measured using a validated survey. A positive culture of safety is associated with the increased reporting of adverse events and the reporting of behaviors which strengthen patient safety efforts.

i. *Assessment:* An assessment tool (developed and validated by AHRQ) which allows comparison to benchmark data is used at CCHHS for the assessment of a safety culture. It is administered at all CCHHS affiliates and is analyzed using national benchmark data.

ii. *Interventions*: Interventions will be performed in 2015 based on the culture of safety survey results to be administered in the Winter of 2015. These include:

a. Leadership walk rounds: These rounds permit leaders to directly communicate safety priorities, support reporting behaviors and to hear staff concerns.

b. Interdisciplinary rounds or huddles: These rounds permit the robust interdisciplinary planning of patient care initiatives, which include improving the patient experience, infection prevention and the

environment of care. These rounds utilize a structured format and are led by clinic based staff.

c. Facility and clinic based safety programs provide opportunities for all staff to participate in quality improvement programs.

**VII. Patient Complaints and Patient Satisfaction:** Patient feedback and perceptions of the safety and quality of care are vitally important to the development of a responsive, patient centered organization. ACHN welcomes feedback, comments and complaints from patients and recognizes that patients and their families have the right to have complaints reviewed by the organization. A complaint resolution process has been realized by the office of the Chief Operating Officer for ambulatory services. Health center and clinic administrators receive, prioritize and respond to all complaints from patients. Serious consideration is given to every complaint and ACHN policy is established regarding the timeliness of resolution. These processes are designed not only to enhance patient satisfaction but to also identify conditions which may impact patient safety.

Structured surveys of selected patient samples seen for office visits are administered by an independent organization. The results are reported to ACHN leadership. This type of feedback from patients is used to restructure processes that support patient safety, communication and patient education.

**VIII. Quality Metrics:** Quality measures are collected and reported to monitor and enhance the quality of care; to report to the federal state and county governments as applicable; for legal and regulatory purposes and to support reimbursement and pay for performance (P4P) initiatives.

a. Alignment with System Priorities: Ambulatory quality priorities support the system priorities to improve access to care, demonstrate excellence in the delivery of care, and improve patient satisfaction. The Ambulatory Key Priority indicators are represented in **APPENDIX G,** which focuses on population health and prevention.

b. Description of Metrics*:* A quality metric allows us to measure performance in different domains(sphere of influence):

i. *Outcome measure* (O) – These measures assess the patient's health status after receiving health care services. It can be used to evaluate the quality of care to the extent that health care services influence the likelihood of desired health outcomes. Examples include outcomes such as glucose control and childhood Immunization compliance.

ii. *Process measure* (P) – These measures assess the actual health care service provided to or on behalf of a patient. Evidence based processes reflect good clinical practice. High levels of achievement in these areas may correlate with good patient outcomes. Examples are post hospital discharge follow-up and telephone access. Timely follow-up and the ability to communicate with care providers are vital toward preventing readmission and repeat ED visits.

iii. *Structural measure* (S) – These measures describe features of a health care organization or clinical relevance to its capacity to provide health care. Examples are the use of CPOE and ePrescribe.

iv. *Population health measures*: These measures apply to groups of persons identified by geographic location, organizational affiliation or non-clinical characteristics, in order to assess public health programs. Communities may have influences on health or population-level health characteristics that may not be directly attributable to the care delivery system. These measures are supported by evidence to demonstrate that they can indicate better or worse performance of population health activities. An example is influenza vaccination.

c. Metric Selection & Data Abstraction: Metrics are selected in support of best practices, evidenced based clinical care and regulatory requirements. They are approved and guided by the Ambulatory Quality council. CCHHS uses computer supported data abstraction through the electronic medical record (EMR) system which supports, the Care Management application (CMApp) and the abstraction of Centers for Medicare & Medicaid Services (CMS) Meaningful use measures.

i. *Quality Council*: The Council reviews data, prioritizes quality initiatives, patient care services, and conducts the review of suggested quality metrics from various work-groups and subcommittees. The membership includes quality improvement staff, nursing directors and medical staff leadership; see **APPENDIX D** for the complete membership listing.

ii. *Preventive Health Subcommittee*: This group promotes the use of evidenced based guidelines from leading practice groups and recommends preventive health practices with standardized approaches to health promotion and wellness. Comparative databases for benchmarking surveillance data are incorporated in collaboration with information technology (IT). The development of EHR decision support tools and documentation redesigns are created through partnership with medicine and nursing.

iii. *Chronic Disease Subcommittees*: These groups encourage population based management of chronic conditions that support improved health outcomes. The committees recommend evidenced based management approaches from leading practice groups in efforts to support the best possible outcomes and decrease the likelihood of patient complications. The use of electronic population based care management registries in collaboration with information technology (IT), for surveillance of condition maintenance and trending is promoted.

iv. *Nursing Council* – This group provides oversight of nursing practice and seeks to influence improved patient outcomes, wellness and safety. Improving communication and education of patients and their families reflects their goal to enhance the overall patient health experience through engagement. Patients and their families play a significant role toward improving the safety and health outcomes of their own care.

d. Data Sources*:* Different data sources are used to assist with the surveillance and evaluation of outcome and process measures. HEDIS, EMR abstraction and CMApp are data sources utilized for these purposes.

i. *HEDIS* - The Healthcare Effectiveness Data and Information Set: A widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). The data provides benchmarks based on national or regional comparisons.

ii. *EMR* - Electronic Medical Record Abstraction: HIS report writers build customized reports as well as supply data and links to support adhoc abstraction. Compliance is measured as a percentage.

iii. *CMApp* – Care Management Application: An electronic registry database linked to the EMR, used for the Patient Centered Primary Care Medical Homes (PCMH) of CCHHS. CMApp focuses on global and individual population based management of patient panels. The following reports are available in CMApp:

- ACHN Quality Goals reports
    a. A1C in 12 months
    b. A1C > 9 in Diabetics
    c. LDL in 12 month
    d. LDL < 100 in Diabetics
    e. Age 1-3 years with Lead screen completed
- Panel reports to support management of patient panel size, provider scheduling and capacity analysis
- Day of care plan report to support day of visit care
- Outreach reports to support the patient list for population management

e. Data Acquisition and Analysis**:** ACHN collects data in a variety of settings to support the quality enterprise. The Board of Directors along with system leadership and the Executive Medical Staff set the priorities for data collection as well as the frequency of data collection. The Board of Directors assures adequate resources to accomplish data acquisition and analyses required for the quality program. The priorities and requirements for data collection for FY 2015 are summarized in the tables in **APPENDICES G and H**. Data is compared to external benchmarks whenever these are available and the significance of the comparison is evaluated using statistical techniques. Data is displayed using run charts which show the evolution of performance over time and is correlated with performance improvement initiatives. The data will be assessed using statistical process control techniques which can differentiate between special and common causes of variation; this information will be used to describe the nature of performance improvement initiatives which can best address variation. The goal is to achieve high reliability in quality measures

**IX. Performance Improvement:** Priorities for performance improvement are established by the organizations leadership, which includes the Quality Committee, Executive Medical Staff, System Leadership and the Board of Directors. High-risk, high-volume or problem prone

areas are prioritized for performance improvement projects after consideration of the incidence, prevalence and severity of problems in these areas and whether these problems are known to affect health outcomes, patient safety and quality of care. Performance improvement projects are proportional to the scope and complexity of ACHN's services, as outlined in **APPENDICES G and H**.

ACHN's approach to performance improvement projects is in a transitional phase from P-D-C-A to a Lean/Six Sigma approach. This choice reflects the emphasis on value in health care operations and the alignment of lean concepts with value and the reduction of waste. This approach accurately reflects the multidisciplinary nature of health care and the processes under study. The lean approach also supports the possibility of rapid cycle performance improvement which may be used in selected cases, particularly in unit based improvement programs. Performance improvement projects will address variation by designing high-reliability interventions which are known to create sustained changes. This includes system redesign, forcing functions, checks and redundancies and consideration of human factors. Monitoring of performance improvement activities will be provided by the ACHN Quality Council. Staff in the department of Quality and Accreditation will process data required for performance improvement projects and provide facilitation for these projects as required.

a. Performance Targets*:* These are determined by the type of data (process or outcome) and by indicator. A subset of process measures has been selected for ACHN for FY 2015, which are listed in **APPENDIX G**. The goal for outcome measures is to achieve all thresholds and set all targets above the national average.

b. External reporting: Quality assessment and reporting of quality metrics include the Meaningful Use, 'PQRS' or process measures required for reporting to CMS and the Joint Commission.
    i. *Meaningful Use (MU)*: Specific objectives are established for eligible professionals (EPs) and hospitals, which must be achieved to qualify for Centers for Medicare & Medicaid Services (CMS) incentive programs. It involves the utilization of a certified electronic health record (EHR) technology to improve quality, safety, efficiency to reduce health disparities. There is a focus on patient and family engagement which involves improved care coordination, population and public health. Logic is built is into the EMR for data abstraction and reporting to CMS. The objectives evolve three stages (1, 2, and 3) over a five year period. The list of Stage 1 Ambulatory Meaningful use objectives is available in **APPENDIX I.**
    ii. *Physician Quality Reporting System (PQRS)*: CCHHS, ACHN and Stroger Hospital clinics will be reporting through the PQRS program for physician specific outpatient quality and Meaningful Use measures. The PQRS metrics that reflect the burden of disease and major risk factors in our ambulatory population are listed in **APPENDIX J**.

X. **Confidentiality**: All information, data, reports, minutes or memoranda relating to the implementation of this Quality Assessment and Performance Improvement plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving patient care. As such, they are strictly confidential under the Illinois Medical Studies and Hospital Licensing Act. The confidentiality of patient specific data will be protected in observance of HIPAA regulations and aggregated, de-identified data will be used whenever possible for quality data reporting.

## APPENDIX A:
## Joint Commission Leadership Standards

**LD.01.03.01**
The governing body is ultimately accountable for the safety and quality of care, treatment and services. The governing body defines in writing its responsibilities

**LD 02.01.01**
The mission vision and goals of the organization support the safety and quality of care, treatment and services.

**LD.02.03.01**
Leaders regularly communicate with each other on issues of safety and quality. Leaders discuss issues that affect the organization and the population it serves, including performance improvement activities, reported safety and quality issues, proposed solutions and their impact on resources, reports on key quality measures and safety indicators, safety and quality issues specific to the population served.

**LD.03.01.01**
Leaders create and maintain a culture of safety throughout the organization. Leaders regularly evaluate the culture of safety and and implement changes identified by the evaluation.

**LD.03.02.01**
The organization uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

**LD 03.03.01**
Leaders use organization wide planning to establish structures and processes that focus on safety and quality

**LD 03.04.01**
The organization communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families and external interested parties.

**LD.03.05.01**
Leaders implement changes in existing processes to improve the performance of the organization. Structures for managing change and performance improvement exist. The organization describes its approach to performance improvement, and its capacity for change support a culture of safety and quality

**LD 03.06.01**
Those who work in the organization are focused on improving safety and quality. Leaders design work processes that focus on safety and quality issues and describe how those who work in the organization support a culture of safety and quality. The effectiveness of those who work in the organization to promote safety and quality is evaluated.

**LD.04.04.01**
Leaders establish priorities for performance improvement; set priorities for performance improvement activities and patient health outcomes, and give priority to high-volume, high-risk or problem prone processes for performance improvement activities.

**LD.04.04.03**
New or modified services and processes are well designed incorporating multiple factors (i.e. patient/staff needs, results of quality activities, information about potential risks, and sentinel event information)

**LD.04.04.05**
The organization has an organization-wide, integrated patient safety program within its performance improvement activities. The leaders implement a hospital-wide patient safety program. One or more qualified individuals or an interdisciplinary group manages the safety program. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors to hazardous conditions and sentinel events. All departments, programs and services within the hospital participate in the safety program.

## APPENDIX B:
## Joint Commission Performance Improvement Standards

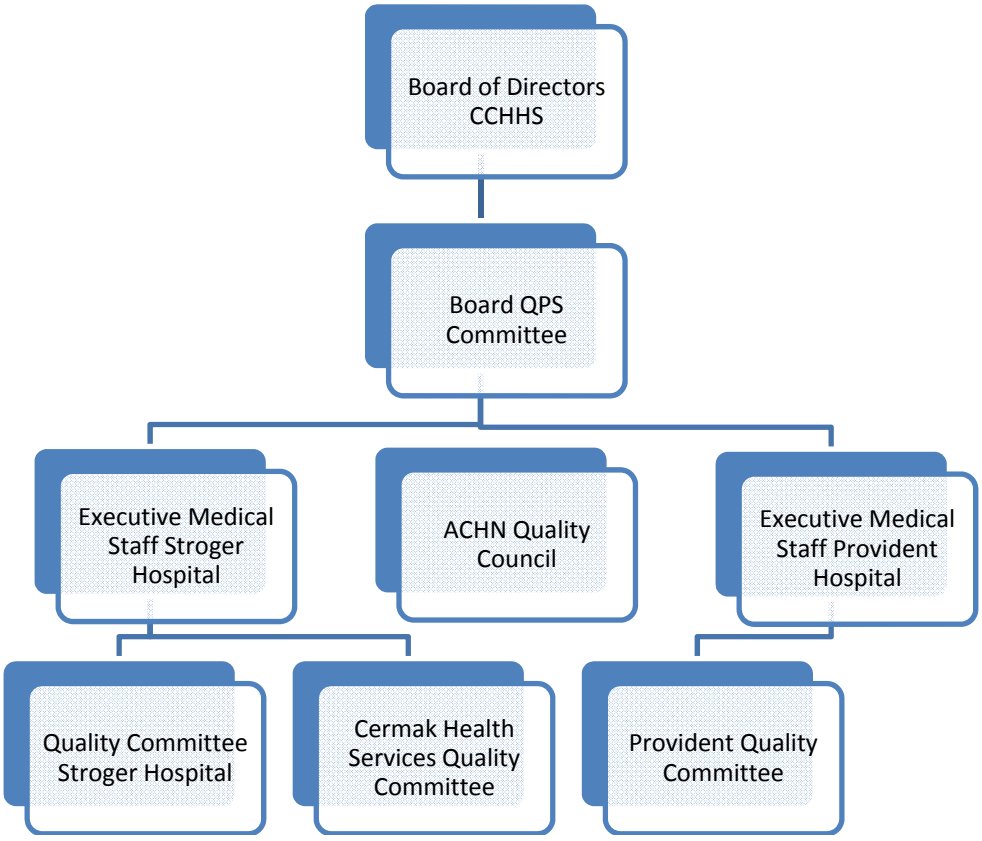
**PI.01.01.01, EP 1-8, 11, 12, 14-16, 30,**
The organization collects data to monitor its performance. Leaders set priorities for data collection. The leaders identify the frequency for data collection. The organization collects data on

- the performance improvement priorities identified by leaders
- operative and other procedures that place the patient at risk of disability or death
- all significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- adverse events related to using moderate or deep sedation
- use of blood and blood components
- all reported and confirmed transfusion reactions
- significant medication errors
- significant adverse drug reactions
- patient perception of the safety and quality of care, treatment, and services
- Considers collecting data on:
    - staff opinion and needs;
    - Staff perception of risks to individual
    - Staff suggestions to improve safety processes
    - Staff willingness to report adverse events

**PI.02.01.01, EP 1, 2,4,5,8**
The organization compiles and analyzes data. The organization compiles data in usable formats, identifies the frequency for data analysis, compares internal data over time to identify levels of performance, patterns, trends and variations, and compares data with external sources, when available and uses the results to identify improvement trends.

**PI.03.01.01, EP 1-4**
The organization improves performance. Leaders prioritize the identified improvement opportunities. The organization takes action on improvement priorities. The organization evaluates actions to confirm that they resulted in improvements, takes action when it does not achieve or sustain planned improvements.

**APPENDIX C:**
**CCHHS Quality Reporting Overview**



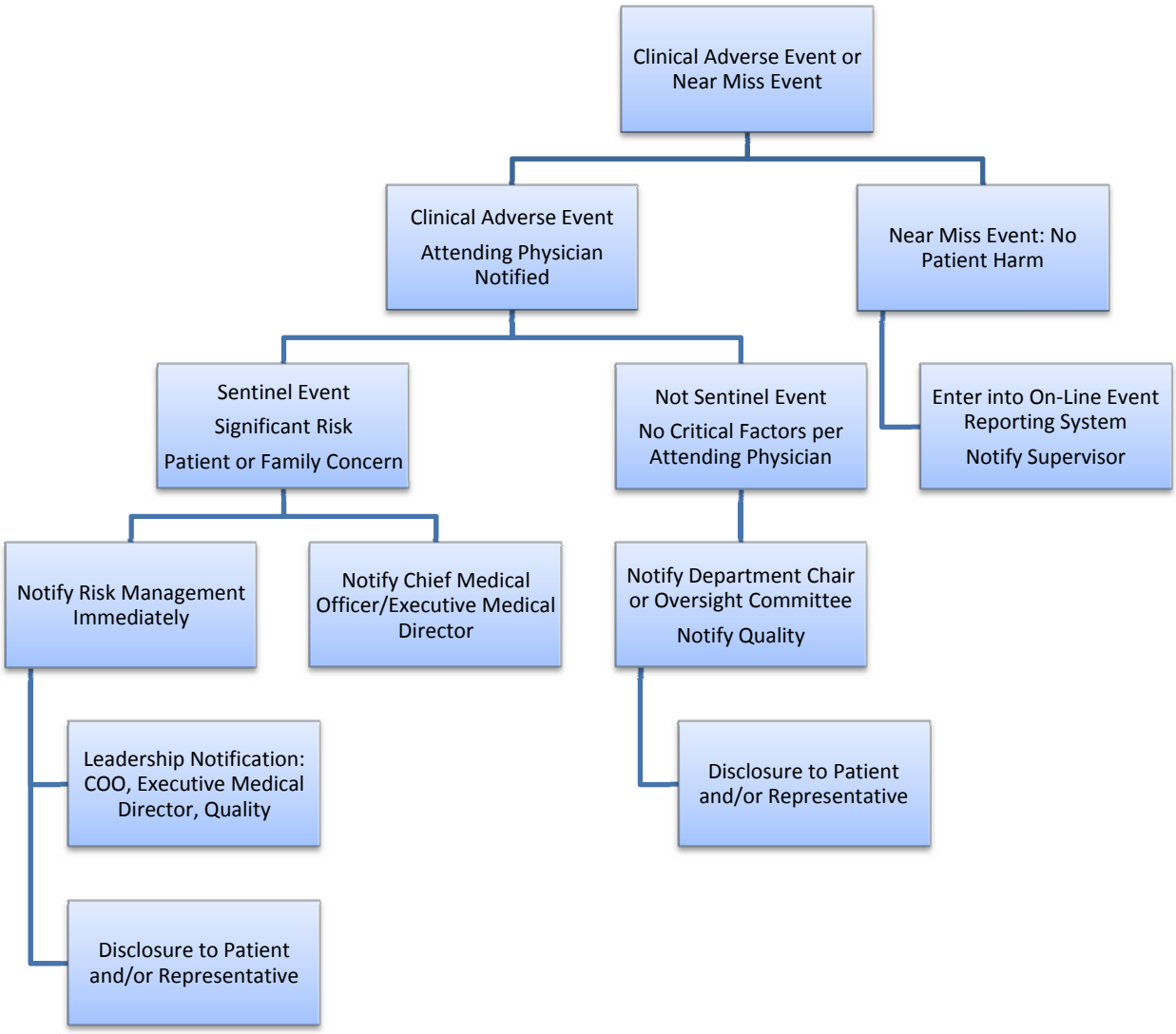

The ACHN Quality Council reports ambulatory metrics to the Board QPS committee either directly through the COO of Ambulatory Services or through the Chief Quality Officer. The ACHN Quality Council communicates with the Executive Medical Staffs as required to support quality improvement and patient safety efforts.

**APPENDIX D:**
**Ambulatory & Community Health Network Quality Council**

***Committee and other Reports to be Received:***


**Council Membership:**
Medical Director, Ambulatory Services
Chief Operating Officer, Ambulatory Services
Director of Nursing, Ambulatory Services
Director Quality & Accreditation Outpatient
Facilities Manager (ACHN)
Chief Quality Officer
Associate Medical Director Primary Care
Associate Director of Quality
Lead Physician Central Campus
Lead Physician North/West
Lead Physician Oak Forest and South Suburban
Lead Physician South Clinic Cluster
Divisional Director Specialty Care Center
Divisional Director Fantus /GMC Clinic
Divisional Director North/West Cluster
Divisional Director South Cluster
Divisional Director South Suburban Cluster
Nurse Clinician Quality ACHN
Care Management Specialist
AA III Quality
Data Analysts

**APPENDIX E:**
**Recognition and Reporting of Adverse Events**



## APPENDIX F:
## Sentinel Events (Joint Commission)

The event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition§ ||

**or**

1. The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition):
2. Suicide of any patient receiving care, treatment and services in a staffed around the-clock care setting or within 72 hours of discharge, including the hospital's emergency department (ED)
3. Unanticipated death of a full-term infant, Abduction of any patient receiving care, treatment, and services
4. Discharge of an infant to the wrong family
5. Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services while on site at the hospital
6. Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization
7. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
8. Invasive procedure, including surgery, on the wrong patient, wrong site, or wrong procedure**
9. Unintended retention of a foreign object in a patient after surgery or other invasive procedures
10. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
11. Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
12. Any elopement (that is unauthorized departure) of a patient from a staffed around the clock care setting (including the ED), leading to death, permanent harm or severe temporary harm.
13. Fire, flame or unanticipated smoke, heat or flashes occurring during an episode of patient care.
14. Any intrapartum (related to the birth process) maternal death or severe maternal morbidity.

**_____

§A distinction is made between an adverse outcome that is primarily related to the natural course of the patient's illness or underlying condition (not reviewed under the Sentinel Event Policy) and a death or major permanent loss of function that is associated with the treatment (including "recognized complications") or lack of treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient's illness or underlying condition (reviewable under the Sentinel Event Policy). In indeterminate cases, the event will be presumed reviewable and the hospital's response will be reviewed under the Sentinel Event Policy according to the prescribed procedures and time frames without delay for additional information such as autopsy results.

||*Major permanent loss of function* means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change. When major permanent loss of function cannot be immediately determined, applicability of the policy is not established until either the patient is discharged with continued major loss of function or two weeks have elapsed with persistent major loss of function, whichever is the longer period.

#*Sexual abuse/assault (including rape),* as a reviewable sentinel event, is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine reviewability:

n Any staff-witnessed sexual contact as described above

n Admission by the perpetrator that sexual contact, as described above, occurred on the premises

n Sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact

**APPENDIX G:**
**Ambulatory Quality Performance Measures Chart 1**

| Indicator | Domain | Target Performance | Baseline Q3 2014 | Benchmark 50th %tile | Benchmark 90th %tile | Data Source | Reporting Interval |
|---|---|---|---|---|---|---|---|
| **ACHN Quality Key Performance Indicators** | | | | | | | |
| *Ease of moving through the clinic 'good' | P | 75% | 63% Internal baseline | 84% Press Ganey Peer group | 88% Press Ganey Peer group | CAHPS survey | Quarterly |
| *Ease of reaching clinic on the phone 'good' | P | 75% | 59% Internal baseline | 86% Press Ganey Peer Group | 91% Press Ganey Peer Group | CAHPS Survey | Quarterly |
| *Children with UTD immunization at 24 months | O | 86% | 71% | 77% HEDIS | 86% HEDIS | Cerner ICARE registry | Quarterly |
| *Diabetics with A1C < 9% | O | 78% | 72% | 71% HEDIS | 81% HEDIS | Cerner | Quarterly |
| *Provide Access for Post Hospital follow-up within 14 days | P | 60% | Establish baseline | 50% MHN Pilot Target | 29% DHFS Target | MHN Connect Dashboard | Quarterly |

**APPENDIX G Cont'd:**
**Ambulatory Quality Performance Measures Chart 2**

| Indicator | Domain | Target Performance | Baseline Q3 2014 | Threshold | Data Source | Reporting Interval |
|---|---|---|---|---|---|---|
| **Patient Safety** | | | | | | |
| **Medication Safety** | | | | | | |
| Medication reconciliation each visit | P | 100% compliance | 75% compliance | 50% MU Stage1 | Cerner | Quarterly |
| CPOE completion | P | 100% compliance | 95% compliance | 60% MU Stage1 | Cerner | Quarterly |
| ePrescribe completion | P | 100% compliance | 94% compliance | 50% MU Stage1 | Cerner | Quarterly |
| **Procedure Safety** | | | | | | |
| Surgical/Invasive procedure Final time-out completion | P | 100% | 100% | 90% TJC | Cerner | Quarterly |
| **Infection Prevention** | | | | | | |
| Hand Hygiene before/after patient and EOC contact | P | 100% | Q2 2014 96% before 96% after | 90% TJC | Hand Hygiene Observation Audit | Quarterly |
| Patient with Annual Influenza Vaccination | p | 90% | 24% 2012/13 Seasonal | 45% CDC | Cerner | Monthly during flu season |
| **Environment of Care** | | | | | | |
| Completion of Environment of Care Rounds | S | 100% | 67% | 100% TJC | Site Audit reports | Quarterly |
| Health Center Annual Emergency Disaster Drill completion | S | 100% | 95% | 100% TJC | Emergency Preparedness Critique form | Annual |

**APPENDIX G Cont'd:**
**Ambulatory Quality Performance Measures Chart 3**

| Indicator | Domain | Target Performance | Baseline Q3 2014 | Benchmark 50th %tile | Benchmark Top 10%tile | Data Source | Reporting Interval |
|---|---|---|---|---|---|---|---|
| **Prevention** | | | | | | | |
| Diabetics with Annual A1C | O | 91% | 92% | 82% HEDIS | 91% HEDIS | Cerner | Quarterly |
| *Diabetics with A1C <9% | O | 78% | 72% | 71% HEDIS | 81% HEDIS | Cerner | Quarterly |
| *Children with UTD immunization at 24 months | O | 86% | 71% | 77% HEDIS | 86% HEDIS | Cerner ICARE registry | Quarterly |
| **Patient Experience** | | | | | | | |
| Patient with Learning Needs Screens | P | 90% | 84% | 90% TJC Threshold | | Cerner | Quarterly |
| *Patient experience and satisfaction related to access and communication 'good' | S | 75% | Establish baseline | 91% Press Ganey Peer Group | 93% Press Ganey Peer Group | CAHPS survey | Quarterly |
| Provide Access for Post hospital follow-up within 14 days | P | 31% | Establish baseline | 50% MHN Pilot Target | 29% DHFS Target | MHN Connect Dashboard | Quarterly |
| *Ease of moving through the clinic 'good' | S | 75% | 63% Internal baseline | 84% Press Ganey Peer group | 88% Press Ganey Peer group | CAHPS Survey | Quarterly |

**APPENDIX H:**
**ACHN – PCMH Requirements**

| OPERATIONAL CHARACTERISTICS & REQUIREMENTS | |
|---|---|
| **Patient Centered Care** | Relationship-based care focuses on the whole person. Requires partnering with the patient, understanding and respecting their needs, culture, values and preferences:<br>• Patient selected Primary Care Provider(PCP)<br>• PCP, healthcare team and patient partnership<br>• Consideration of patient's preferences, cultural, linguistic & education needs<br>• Patient involvement in establishing the treatment plan<br>• Support for patient self-management |
| **Comprehensive Care** | Team-based health care with providers and other health care workers and services, working together to meet the complete needs of the patient:<br>• Provision of acute, preventive, chronic, continuous and comprehensive care<br>• Team-based approach and the use of team approach to provide care<br>• Use of external and internal resources to meet patients' needs<br>• PCP background and experience to handle healthcare needs<br>• Care addressing phases of lifespan, including end of life care<br>• Disease management |
| **Coordinated Care** | Care is coordinated across the broader health care system, including specialty care, hospitals, home care, community services and support. Transitions of care between care sites with focused emphasis on discharges from hospitals and emergency departments:<br>• Use of internal and external resources to meet patients' needs<br>• Responsibility for care coordination<br>• Team-based approach |
| **Superb Access to care** | Services are accessible with shorter waiting times for urgent needs. Enhanced in-person hours, around the clock telephone or electronic access is to the care team provided. Alternative methods of communication such as e-mail and telephone are available:<br>• Enhanced access –timely responses to patients needs<br>• 24/7 availability<br>• Access for special communication and non-visit patient needs |
| **System-based approach to quality and safety** | Using evidenced based medicine and clinical decision support tools to guide decision making. Using data to manage population health, chronic disease and performance improvement:<br>• Population based care and care of patient panel<br>• Use of Health IT for eRX and CPOE<br>• Use of evidence based medicine and decision support tools<br>• Patient involvement in performance improvement efforts |

**APPENDIX H Cont'd**
**ACHN PCMH Key Metrics**

| Indicator | Domain | Threshold Requirement | Data Source | Reporting Interval |
|---|---|---|---|---|
| **Comprehensive Care & Care Coordination** External Referral Submission & Completion | P | 90% TJC | Cerner | Quarterly |
| **24/7 Access**: Portal/Phone message follow-up completion | P | 90% TJC | Cerner | Quarterly |
| **Patient Centeredness** Self-Management Goal(s) documented for Diabetics | O | 90% TJC | Cerner | Quarterly |
| **Quality & Safety** Clinical Decision support influenza rule orders and vaccination completion | P | 90% TJC | Cerner | Quarterly |

**APPENDIX I**
**Ambulatory Meaningful Use Stage 1-Eligible Provider (EP) Measures**

| Meaningful Use objectives | Threshold Requirement | % Compliance Q3 2014 | Data Source | Frequency |
|---|---|---|---|---|
| CPOE for medication orders | 30% | 95% | Cerner | Quarterly |
| Incorporate lab results | 40% | 97% | Cerner | Quarterly |
| Maintain active medication allergy list | 80% | 97% | Cerner | Quarterly |
| Maintain active medication list | 80% | 92% | Cerner | Quarterly |
| Maintain up to date problem list | 80% | 98% | Cerner | Quarterly |
| Perform medication reconciliation | 50% | 75% | Cerner | Quarterly |
| Provide Depart Summary | 50% | 70% | Cerner | Quarterly |
| Record Patient Demographic | 50% | 99% | Cerner | Quarterly |
| Provide Patient education | 10% | 98% | Cerner | Quarterly |
| Record and chart changes in vital signs | 50% | 98% | Cerner | Quarterly |
| Record smoking status | 50% | 97% | Cerner | Quarterly |
| Patient Reminders | 20% | 60% | Cerner | Quarterly |
| Transmit prescriptions electronically | 40% | 94% | Cerner | Quarterly |
| View-Download-Transmit | 20% | 98% | Cerner | Quarterly |

**APPENDIX J**

**PQRS - Physician Quality Reported System**

| Clinical Quality Measure | National Quality Strategy Domain | Data Source | Frequency |
|---|---|---|---|
| Pneumonia Vaccination Status for Older Adults | Clinical Process/ Effectiveness | Cerner | Quarterly |
| Use of High-Risk Medications in the Elderly | Patient Safety | Cerner | Quarterly |
| Diabetes: Hemoglobin A1c Poor Control | Clinical Process/ Effectiveness | Cerner | Quarterly |
| Hemoglobin A1c Test for Pediatric Patients | Clinical Process/ Effectiveness | Cerner | Quarterly |
| IVD: Use of Aspirin or Another Antithrombotic | Clinical Process/ Effectiveness | Cerner | Quarterly |
| Controlling High Blood Pressure | Clinical Process/ Effectiveness | Cerner | Quarterly |
| Appropriate Testing for Children with Pharyngitis | Population Health | Cerner | Quarterly |
| Childhood Immunization Status | Population Health | Cerner | Quarterly |
| Appropriate Treatment for children with Upper Respiratory Infection | Efficiency & Resource Use | Cerner | Quarterly |
| Preventive Care: Tobacco Use Screening and Cessation Intervention | Population Health | Cerner | Quarterly |
| Breast Cancer Screening: Women 50-74 | Clinical Process/ Effectiveness | Cerner | Quarterly |
| Cervical Cancer Screening: Women 21-64 | Clinical Process/ Effectiveness | Cerner | Quarterly |
| Colorectal Cancer Screening: Adults 50-75 | Clinical Process/ Effectiveness | Cerner | Quarterly |
| Documentation of Current Medications | Patient Safety | Cerner | Quarterly |
| Body Mass Index (BMI) Screening and follow-up | Population Health | Cerner | Quarterly |
| Preventive Care and Screening: Influenza Immunization | Population Health | Cerner | Quarterly |

ATTACHMENT #4

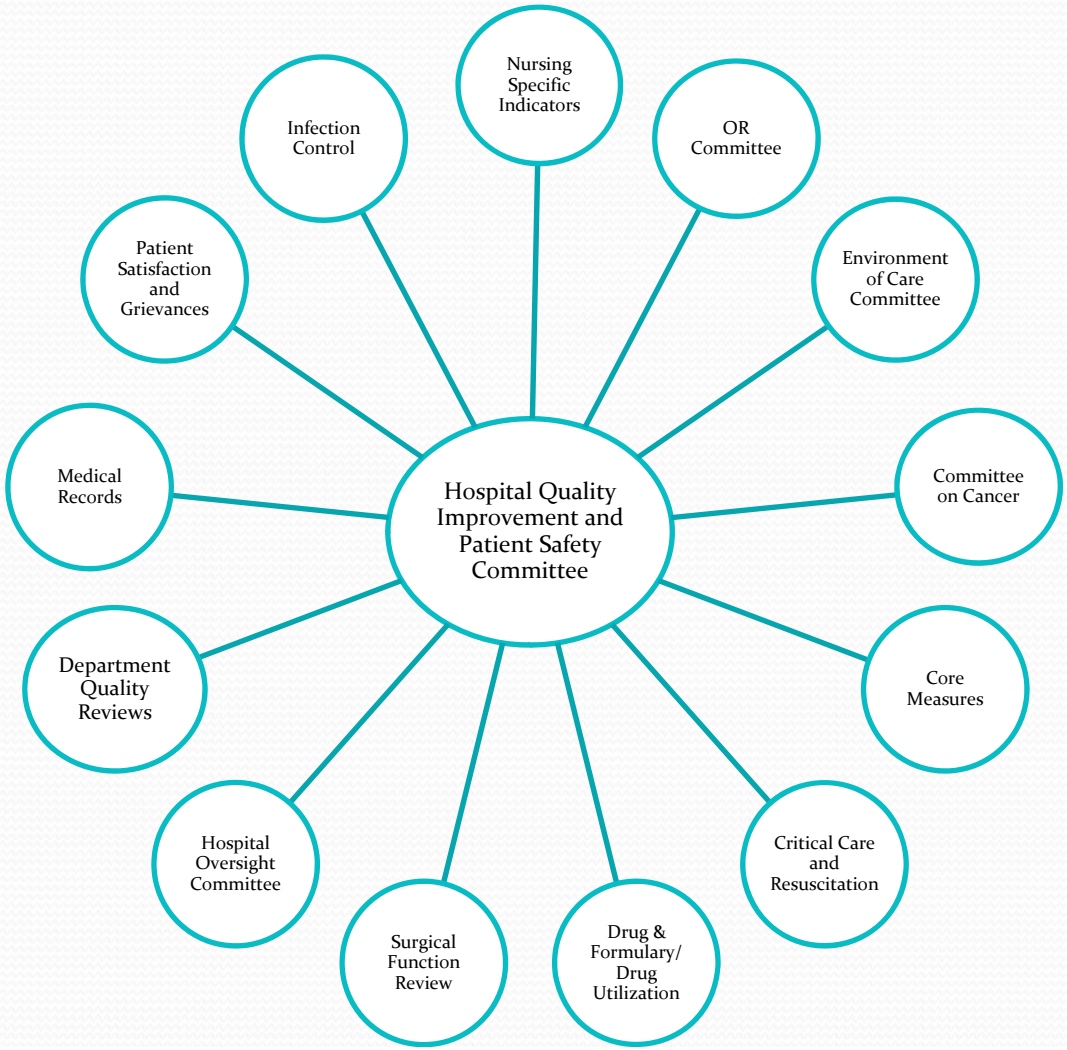
# Stroger Hospital Quality Assessment and Performance Improvement Plan 2015

Quality and Patient Safety Committee
CCHHS Board of Directors
9 December 2014

# Stroger Hospital Goals of the Plan

- Provide the regulatory framework guiding the development of a quality plan
- Describe the structure and reporting responsibilities of quality committees
- Describe basic requirements for a patient safety program including the evaluation and management of adverse events
- Describe required quality reporting and priorities for performance improvement
- Discuss the preferred approach to data handling and clinical performance improvement

# Hospital Wide Quality Improvement and Patient Safety Committee: Reports Received



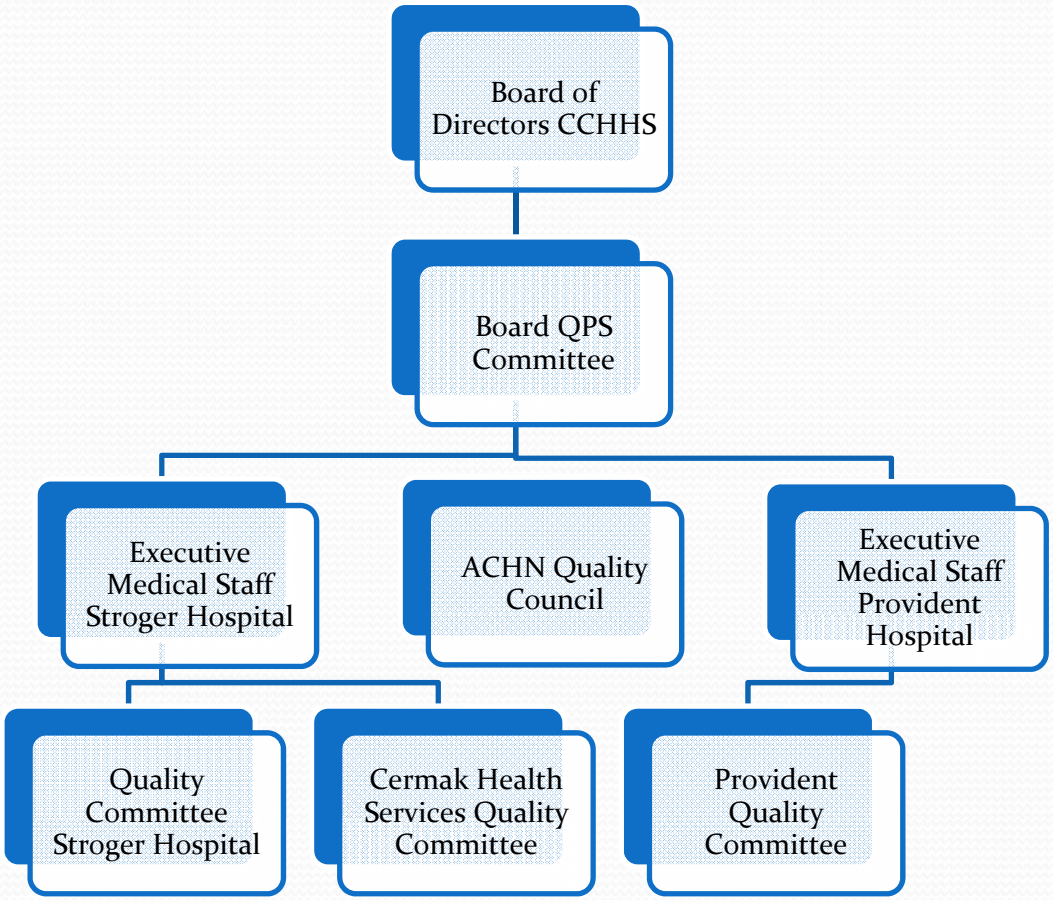
# Hospital Wide Quality Improvement and Patient Safety Committee: Membership

- President, Executive Medical Staff
- Medical Dept Chairs
- Executive Medical Director
- COO, Hospital Services
- COO, Ambulatory Services
- Chief Nursing Officer (Stroger)
- Chief Quality Officer (System)
- Chief Financial Officer
- Chief of Clinical Informatics
- Director of Supply Chain
- Director of Health Information
- Director of Patient Experience
- Director of Pharmacy
- Director of Infection Control
- Committee Chair (if not listed above)
- Committee Vice Chair (if not listed above)

- *Ex Officio Members*

- Executive Director of Nursing
- Director of Multicultural Affairs
- Chief Financial Officer (System)
- Chief Medical Information Officer (System)
- Chair, Quality and Patient Safety Committee, CCHHS Board of Directors
- Quality Staff

# Quality Governance & Reporting



# Key Indicators

- Hospital-wide indicators describe areas of focus for 2015
- Includes type and source of data, and baseline and target performance
- Reflects priorities:
  - Access to care
  - Quality of care
  - Patient satisfaction
- Will be reported regularly to quality committees and the Board
- Full set of indicators is as reflected in CMS reporting requirements and described in the Quality Plan

- First, review of achievement of 2014 indicators

# Stroger Hospital
# Key Performance Indicators 2014

| Indicator | Baseline [1] Q3 2013 | Current Q3 2014 | Target | 50th %ile | 90th %ile [2] | Reporting Interval |
|---|---|---|---|---|---|---|
| AMI | 98.8 | 99.5 | 100 | 98.9 | 100 | Quarterly |
| Heart Failure | 97.2 | 100 | 100 | 98.5 | 100 | Quarterly |
| Pneumonia | 91.5 | 100 | 100 | 98.1 | 100 | Quarterly |
| SCIP Surgical Care | 99 | TBA | 100 | 97.1 | 100 | Quarterly |
| ED Registration to Discharge (Outpt) | 347 min | 269 min | 240 min | 133 min | 93 min | Quarterly |
| ED Registration to Admission (Inpt) | 620 min | 440 min | 480 min | 272 min | 175 min | Quarterly |
| Pt. Satisfaction: Recommend the Hospital | 61 | 67 | 71 | 72.4 | 84.7 | Quarterly |

1 All values in percents except as stated
2 Core measure comparison data through Q1 2014 'Hospital Compare Preview Report'; CMS

# Stroger Hospital
# Key Nursing Indicators 2014

| Indicator | Baseline [1] Q3 2013 | Current Q3 2014 | Target | 50th %ile | 90th %ile | Reporting Interval |
|---|---|---|---|---|---|---|
| Falls/ Falls with Injury[2] | 1.0 | 0.7 | Decrease by 25% | | | Quarterly |
| Hospital Acquired Pressure Ulcers[2] | 3.0 | 0.6 | Decrease by 25% | | | Quarterly |
| Communication with Nurses is good | 63 | 69 | 79.5 | 79.5 | 85.7 | Quarterly |

1 All values in percents except as stated
2 Data normalized to 1000 patient-days

# Stroger Hospital
# Key Performance Indicators 2015

| Indicator[1] | Baseline Q3 2014 | Target | 50th %ile[2,3] | 90th %ile | Reporting Interval |
|---|---|---|---|---|---|
| Operating Room: OR on-time starts (%) | 37 | 80 | 64 | 88 | Quarterly |
| Operating Room: OR room turnaround time (minutes) | 51 min | 35 min | 29 min | 23 min | Quarterly |
| Core Measure: VTE Prophylaxis General Care | 91 | 99 | 88 | 99 | Quarterly |
| Prevention: Influenza Vaccination | 75 | 90 | 93 | 100 | Quarterly |
| Patient Satisfaction: Recommend the Hospital | 67 | 84.7 | 72.4 | 84.7 | Quarterly |

1 All values in percents except as stated
2 Core measure comparison data through Q1 2014 'Hospital Compare preview report'; CMS
3 Surgical benchmarks; various expert sources

# Stroger Hospital
# Key Performance Indicators -- Nursing

| Indicator | Baseline Q3 2014 | Target | 50th %ile | 90th %ile * | Reporting Interval |
|---|---|---|---|---|---|
| Patient Satisfaction: Communication with Nurses is 'good' | 69 | 85.7 | 79.5 | 85.7 | Quarterly |
| Fall rate/ falls with injury | 0.6 | 25% reduction | - | - | Quarterly |
| Hospital Acquired Pressure Ulcers (HAPU) | 0.6 | 25% reduction | - | - | Quarterly |

1 All values in percents except as stated
2 Core measure comparison data through Q1 2014

# Departmental Indicators

- Each department reviews its performance on a range of indicators under the leadership of the Chair of the Department
- Departments may have additional indicators which are reported to the Quality Committee
- All departments will report compliance with clinical contracts affecting their department
- All departments will report OPPE and FPPE for inclusion in personnel files
- All departments will report results of oversight activities

# Departmental Indicators

| Department | Indicators | Data Source(s) | Frequency |
|---|---|---|---|
| Anesthesia | • Use of WHO check list<br>• Handoff to PACU staff<br>• Moderate sedation assessment | Cerner Lighthouse<br>Cerner IView | Quarterly |
| Correctional Health | • Grievance response times<br>• Nurse request reviewed in 24 hours | Local Abstraction | Semiannual |
| Emergency Med | • Registration to provider (outpatient)<br>• Registration to admission (inpatient)<br>• Time to treatment long bone fractures | Cerner Lighthouse | Quarterly |
| Family Med | • VTE prophylaxis -- inpatients<br>• Influenza vaccine – inpatients<br>• Influenza vaccine – outpatients<br>• Patients with appt 14 days post discharge | Lighthouse Cerner reports | Quarterly |
| Internal Med | • VTE prophylaxis -- inpatients<br>• Influenza vaccine – inpatients<br>• Influenza vaccine – outpatients<br>• Patients with appt 14 days post discharge | Lighthouse Cerner reports | Quarterly |
| Obstetrics/ Gynecology | • Caesarean section rate<br>• Elective delivery 37-39 weeks<br>• Breast feeding initiation<br>• Skin to skin contact time | OB database | Quarterly |
| Oral Health | • Chart review compliance<br>• Adverse event review | Chart review | Semiannual |

# Departmental Indicators

| Department | Indicators | Data Source(s) | Frequency |
|---|---|---|---|
| Pathology | • TAT CBC and PT/PTT for ED<br>• TAT blood product delivery to Provident<br>• Inpatient early morning draw refusal rate<br>• Critical results reported -- inpatient | Lab system | Quarterly |
| Pediatrics | • Mortality in v. low birth weight infants<br>• Pediatric immunization rates<br>• Appropriate asthma care | VON network<br>CMApp<br>Cerner | Quarterly |
| Psychiatry | • Outpatient clinic show rates<br>• Post natal depression screen<br>• Lab ordering and results follow-up | Chart review | Quarterly |
| Radiology | • TAT Emergency Studies: Arch and Ectopic<br>• Contrast: abdominal CT<br>• Contrast: thoracic CT | Cerner<br>PACS data | Quarterly |
| Surgery | • SCIP: glucose control<br>• Intraoperative deaths/ 30 day mortality<br>• Unplanned Re-operation within 7 days | Cerner<br>Lighthouse<br>Cerner reports | Quarterly |
| Trauma | • Time to from Resus to Operating room<br>• Negative laparotomy rate<br>• Time from Resus to Burn ICU | Chart review<br>Cerner | Quarterly |

# Performance Improvement Requirements- The Joint Commission

- Operative procedures
- Discrepancies between pre-op and post-op diagnoses
- Adverse events related to moderate or deep sedation
- Use of blood transfusions & transfusion reactions
- Results of resuscitation & response to changes in a patient's condition
- Behavior management/ restraint use
- Significant medication errors and adverse drug reactions
- Fall reduction activities
- Organ procurement conversion rate
- Patient perceptions of treatment
- Staff opinions, needs & perception of risk to individuals

# Medical Staff Committees

| Committee | Indicators | | | Data Source | Reporting Frequency |
|---|---|---|---|---|---|
| Blood Bank & Transfusion | Transfusion Reactions | Red Cells -- Appropriate | Platelets -- Appropriate | Chart review | Semiannual |
| Cancer Committee | Quality project - prevention | Registry Report | Psychosocial Evaluation | Abstraction<br>Chart Review | Semiannual |
| Critical Care & Resuscitation | Ventilator complication rate | Restraint prevalence & complications | Resuscitation Results | Inf Control data<br>Nursing review<br>GWTG data | Semiannual |
| Drug Usage Evaluation | # ADRs reported monthly | Allergy alerts overridden by user | Drug-lab alerts overridden | Incident Reporting system; Cerner | Annual |
| Environment of Care | Fire Safety | Integrity Fire Doors | Completion of EOC Rounds | EOC rounds | Semiannual |
| Infection Control | CAUTI rate | CLABSI rate | Handwashing Compliance | Infection control dept | Semiannual |
| Medical Education | Medication reconciliation performed | Enunciate knowledge re DC safety | Satisfaction with doctors | Cerner<br>HCAHPS<br>Survey | Annual |
| Medical Information | DC summary completed 30 d | Operative notes completed | Admission H&P signed 48 hours | Cerner reports | Quarterly |
| Nursing Quality | HAPU report | Fall report | Patient Experience Nursing | Surveys<br>Chart review<br>Cerner reports | Quarterly |
| Operating Room | Use of time outs | Room TAT | On time starts | Chart reviews<br>Incident reports | Quarterly |
| Patient Safety Council | eMERS Summary | Monthly Patient Safety Events | Time from Last Sentinel Event | eMERS<br>Chart review | Quarterly |
| Surgical Function Review | Discrepancies pre and post op dx | % Malignant Path reported in 7 days | % PAP smears F/U in one month | Lab system reports | Quarterly |

# Use of Data in Performance Improvement

Current evaluation methods:

- Plan-Do-Check-Act method
- Data display – dashboard format
- Data display – run charts to show improvement over time
- Performance improvement activity is reported to the Quality Committee

Proposed evaluation methods:

- Proposed improvement methodology: transition to lean methods to focus on process and efficiency
- Intermediate steps: statistical process control charts to display of QI data
- Increase staff training in lean/six sigma concepts
- Use selected projects to apply concepts

ATTACHMENT #5

December 5, 2014

Dear members of the Quality and Patient Safety Committee:

Please be advised that the Executive Medical Staff of John H. Stroger Jr. Hospital of Cook County, at its November 18th, 2014 meeting, and an Executive Medical Staff electronic poll concluded today, has recommended the actions on the enclosed list. It is being presented to you for your consideration.

Respectfully

Ozuru O. Ukoha, MD
President, EMS

# John H. Stroger, Jr. Hospital of Cook County

**Medical Staff and Non-Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee**

## INITIAL APPOINTMENT APPLICATIONS

| | | |
|---|---|---|
| Braniecki, Marylee, MD<br>Appointment Effective: | Pathology<br>December 9, 2014 thru December 8, 2016 | Consulting Physician |
| Hafez, Nadim, MD<br>Appointment Effective: | Emergency Medicine<br>December 9, 2014 thru December 8, 2016 | Consulting Physician |
| Jha, Kamlesh, MD<br>Appointment Effective: | Pediatrics/Neonatology<br>December 9, 2014 thru December 8, 2016 | Voluntary Physician |
| Mantis, Stelios, MD<br>Appointment Effective: | Pediatrics/Endocrinology<br>December 9, 2014 thru December 8, 2016 | Voluntary Physician |
| Mehlinger, Renee D, MD<br>Appointment Effective: | Psychiaty/Juvenile Detention Center<br>December 9, 2014 thru December 8, 2016 | Active Physician |
| Moncayo, Ruth E, MD<br>Appointment Effective: | Anesthesiology/Pediatrics<br>December 9, 2014 thru December 8, 2016 | Active Physician |

## INITIAL APPOINTMENT NON-PHYSICIAN APPLICATIONS

| | | |
|---|---|---|
| Dzidza, Thompson, PA-C<br>With Paul, Reena D, MD<br>Alternate Dawalibi, Salim J, MD<br>Effective: | Correctional Health Services<br>December 9, 2014 thru December 8, 2016 | Physician Assistant |
| Follenweider, Linda M, CNP<br>With Conway, Terrence J, MD<br>Effective: | Medicine/General Medicine<br>December 9, 2014 thru December 8, 2016 | Nurse Practitioner |
| Galvez, Edgardo L, CNP<br>With Kelleher, Patricia, MD<br>Effective: | Medicine/General Medicine<br>December 9, 2014 thru December 8, 2016 | Nurse Practitioner |
| George, Kathryn E, PA-C<br>With Schindlbeck, Michael A, MD<br>Alternate Lewis, Trevor, MD<br>Effective: | Emergency Medicine<br>December 9, 2014 thru December 8, 2016 | Physician Assistant |

## REAPPOINTMENT APPLICATIONS

### Department of Anesthesiology

| | | |
|---|---|---|
| Durrani, Zia U, MD<br>Reappointment Effective: | Pain Management<br>January 23, 2014 thru January 22, 2016 | Active Physician |
| Rahman, Abed, MD<br>Reappointment Effective: | Pain Management<br>January 23, 2014 thru January 22, 2016 | Active Physician |

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ON DECEMBER 9, 2014

## John H. Stroger, Jr. Hospital of Cook County
## Reappointment Applications (continued)

### Department of Correctional Health Services

| | | |
|---|---|---|
| Lassen, Elizabeth Paige, DO<br>Reappointment Effective: | Psychiatry/Cermak<br>January 23, 2014 thru January 22, 2016 | Active Physician |
| Tronshaw, Tapatia, MD<br>Reappointment Effective: | Psychiatry/Juvenile Detention Center<br>January 23, 2014 thru January 22, 2016 | Voluntary Physician |

### Department of Emergency Medicine

| | | |
|---|---|---|
| Erickson, Timothy, MD<br>Reappointment Effective: | Emergency Medicine<br>January 23, 2014 thru January 22, 2016 | Voluntary Physician |
| Guerrero, Pilar, MD<br>Reappointment Effective: | Emergency Medicine<br>December 18, 2014 thru December 17, 2016 | Active Physician |
| Gussow, Leon, MD<br>Reappointment Effective: | Toxicology<br>December 16, 2014 thru December 15, 2016 | Voluntary Physician |
| Harter, David, MD<br>Reappointment Effective: | Emergency Medicine<br>January 23, 2014 thru January 22, 2016 | Voluntary Physician |

### Department of Medicine

| | | |
|---|---|---|
| Attar, Bashar, MD<br>Reappointment Effective: | Gastroenterology<br>December10, 2014 thru December 9, 2016 | Active Physician |
| Albrecht, Joerg, MD<br>Reappointment Effective: | Dermatology<br>January 23, 2015 thru January 22, 2017 | Active Physician |
| Franco-Sadud, Ricardo, MD<br>Reappointment Effective: | Hospital Medicine<br>December 14, 2014 thru December 13, 2016 | Voluntary Physician |
| Ganschow, Pamela S, MD<br>Reappointment Effective: | General Medicine<br>January 18, 2015 thru January 13, 2017 | Active Physician |
| Khandelwal, Sonali, MD<br>Reappointment Effective: | Rheumatology<br>January 18, 2015 thru January 17, 2017 | Voluntary Physician |
| Lacuesta, Evelyn, MD<br>Reappointment Effective: | Endocrinology<br>December 18, 2014 thru December 17, 2016 | Active Physician |
| Mba, Benjamin, MD<br>Reappointment Effective: | Hospital Medicine<br>December 13, 2014 thru December 12, 2016 | Active Physician |
| Mason, Thomas A, MD<br>Reappointment Effective: | Medicine/ACHN<br>December 9, 2014 thru December 8, 2016 | Active Physician |
| Rivas Chicas, Oscar R,<br>Reappointment Effective: | Gastroenterology<br>January 18, 2015 thru January 17, 2017 | Active Physician |
| Sengupta, Mandira, MD<br>Reappointment Effective: | Rheumatology<br>January 18, 2015 thru January 17, 2014 | Active Physician |
| Singleton, Lafayette, MD<br>Reappointment Effective: | Neurology<br>December 18, 2014 thru December 17, 2016 | Active Physician |

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## John H. Stroger, Jr. Hospital of Cook County
## Reappointment Applications
## Department of Medicine (continued)

| | | |
|---|---|---|
| Uday, Shreeyala, MD<br>Reappointment Effective: | Medicine/ACHN<br>December 14, 2014 thru December 13, 2016 | Active Physician |
| Zehra, Tharanum, MD<br>Reappointment Effective: | General Medicine/ACHN<br>January 18, 2015 thru January 17, 2017 | Active Physician |

## Department of Obstetrics and Gynecology

| | | |
|---|---|---|
| Abrego, Fidel, MD<br>Reappointment Effective: | Obstetrics and Gynecology<br>January 18, 2014 thru January 17, 2016 | Active Physician |
| Fish, Karen, MD<br>Reappointment Effective: | Obstetrics and Gynecology<br>January 18, 2014 thru January 17, 2016 | Active Physician |
| Hudson-White, Carmen, MD<br>Reappointment Effective: | Obstetrics and Gynecology<br>December 9, 2014 thru December 8, 2016 | Voluntary Physician |
| Pelta, Murray, MD<br>Reappointment Effective: | Obstetrics and Gynecology<br>January 23, 2014 thru January 22, 2016 | Voluntary Physician |

## Department of Pathology

| | | |
|---|---|---|
| Harper, Terence, MD<br>Reappointment Effective: | Anatomic Pathology<br>December 18, 2014 thru December 17, 2016 | Active Physician |

## Department of Pediatrics

| | | |
|---|---|---|
| Khan, Salman, MD<br>Reappointment Effective: | Peds/ACHN<br>December 11, 2014 thru December 10, 2016 | Active Physician |
| Hast, Howard, MD<br>Reappointment Effective: | Peds Critical Care<br>January 23, 2014 thru January 22, 2016 | Voluntary Physician |
| Jandeska, Sara, MD<br>Reappointment Effective: | Pediatrics<br>January 23, 2014 thru January 22, 2016 | Voluntary Physician |
| McConnie, Randolph, MD<br>Reappointment Effective: | Pediatrics<br>December 18, 2014 thru December 17, 2016 | Voluntary Physician |

## Department of Psychiatry

| | | |
|---|---|---|
| Watts, Jeffrey, MD<br>Reappointment Effective: | Psychiatry<br>December 28, 2014 thru December 27, 2016 | Active Physician |

## Department of Radiology

| | | |
|---|---|---|
| Kay, Daniel, MD<br>Reappointment Effective: | Radiology<br>January 18, 2014 thru January 17, 2016 | Active Physician |
| Tailor, Kallolini S, MD<br>Reappointment Effective: | Radiology<br>December 31, 2014 thru December 30, 2016 | Active Physician |

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## John H. Stroger, Jr. Hospital of Cook County
## Reappointment Applications (continued)

### Department of Surgery

| | | |
|---|---|---|
| Abcarian, Herand, MD<br>Reappointment Effective: | Colon/Rectal<br>January 18, 2015 thru January 17, 2017 | Active Physician |
| Chan, Edie Y, MD<br>Reappointment Effective: | General Surgery<br>January 23, 2015 thru January 22, 2017 | Voluntary Physician |
| Giovingo, Michael C, MD<br>Reappointment Effective: | Ophthalmology<br>December 18, 2014 thru December 17, 2016 | Active Physician |
| Greager II, John A MD<br>Reappointment Effective: | Surgical Oncology<br>December 9, 2014 thru December 8, 2016 | Voluntary Physician |
| Greenberg, David M, MD<br>Reappointment Effective: | Ophthalmology<br>December 9, 2014 thru December 8, 2016 | Consulting Physician |
| Jacobs, Chad E, MD<br>Reappointment Effective: | Vascular Surgery<br>December 9, 2014 thru December 8, 2016 | Voluntary Physician |
| Keen, Richard R, MD<br>Reappointment Effective: | Vascular Surgery<br>December 15, 2014 thru December 14, 2016 | Active Physician |
| Marcus, Elizabeth A, MD<br>Reappointment Effective: | Breast Oncology<br>December 9, 2014 thru December 8, 2016 | Active Physician |
| Raksin, Patricia B, MD<br>Reappointment Effective: | Radiology<br>December 14, 2014 thru December 13, 2016 | Active Physician |
| Warren, William H, MD<br>Reappointment Effective: | Cardiothoracic<br>December 9, 2014 thru December 8, 2016 | Active Physician |
| Williams, Kenya M, MD<br>Reappointment Effective: | Radiology<br>December 9, 2014 thru December 8, 2016 | Consulting Physician |

### Department of Trauma

| | | |
|---|---|---|
| Dennis, Andrew, DO<br>Reappointment Effective: | Burn Unit<br>December 9, 2014 thru December 8, 2016 | Active Physician |
| Kaminsky, Matthew J, MD<br>Reappointment Effective: | Trauma<br>December 9, 2014 thru December 8, 2016 | Voluntary Physician |

### Renewal of Privileges for Non-Medical Staff

| | | |
|---|---|---|
| Barnes, Brenda L, PA-C<br>With Nasr, Isam F, MD<br>Alternate Bailitz, John M, MD<br>Effective: | Emergency Medicine<br><br><br>December 9, 2014 thru December 8, 2016 | Physician Assistant |
| Freeman, Bethann, PA-C<br>With Moskoff, Jordan B, MD<br>Alternate Schabowski, Shari, MD<br>Effective: | Emergency Medicine<br><br><br>December 9, 2014 thru December 8, 2016 | Physician Assistant |
| Gallagher, Maureen A., CNP<br>With Badri, Sheila M., MD<br>Effective: | Medicine / Infectious Disease<br><br>December 9, 2014 thru December 8, 2016 | Nurse Practitioner |

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## John H. Stroger, Jr. Hospital of Cook County
## Renewal of Privileges for Non-Medical Staff (continued)

| | | |
|---|---|---|
| Huber, Andrea K.. PA-C<br>With Schaider, Jeffrey MD<br>Alternate Moskoff, Jordan B., MD<br>Effective: | Emergency Medicine<br><br><br>January 23, 2015 thru January 22, 2017 | Physician Assistant |
| Jackson, Rachel M., CNP<br>With Henry-Reid, Lisa M., MD<br>Effective: | Pediatrics / Adolescent Medicine<br><br>December 9, 2014 thru December 8, 2016 | Nurse Practitioner |
| Joseph, Elsy T, CNP<br>With Kulik, Andrew Segovia, MD<br>Effective: | Psychiatry<br><br>December 9, 2014 thru December 8, 2016 | Nurse Practitioner |
| Lange, Jane A., CNP<br>With Hollowell, Courtney M.P., MD<br>Effective: | Surgery / Urology<br><br>December 9, 2014 thru December 8, 2016 | Nurse Practitioner |
| Miller, Barbara J., PA-C<br>With Yordan, Edgardo, MD<br>Alternate Sharma, Sameer, MD<br>Effective: | OB/GYN / Gynecology<br><br><br>December 9, 2014 thru December 8, 2016 | Physician Assistant |
| Novak, Mary Frances, CRNA<br>Effective: | Anesthesiology<br>December 9, 2014 thru December 8, 2016 | Nurse Anesthetist |
| Powers, Kathleen E., PA-C<br>With Marcus, Elizabeth A., MD<br>Alternate Monahan, Denise A., MD<br>Effective: | Surgery / Surgical Oncology<br><br><br>December 9, 2014 thru December 8, 2016 | Physician Assistant |
| Rogowski, Wendy A., PA-C<br>With Lad, Thomas E., MD<br>Alternate Mullane, Michael R., MD<br>Effective: | Medicine/Hematology/Oncology<br><br><br>December 9, 2014 thru December 8, 2016 | Physician Assistant |
| Sithichoke-Rattan, Noi, CNP<br>With Marcus, Elizabeth A., MD<br>Effective: | Surgery / Breast Oncology<br><br>December 9, 2014 thru December 8, 2016 | Nurse Practitioner |
| Soriano, Alexandra, PA-C<br>With Sergel, Michelle J, MD<br>Alternate Bowman, Steven H., MD<br>Effective: | Emergency Medicine<br><br><br>January 27, 2015 thru January 26, 2017 | Physician Assistant |
| Stoltzner, Leslie A., CCP<br>Effective: | Surgery / Cardiothoracic<br>January 18, 2015 thru January 17, 2017 | Perfusionist |
| Williamson, Willa L., CNP<br>With Hollowell, Courtney M.P., MD<br>Effective: | Surgery / Urology<br><br>December 9, 2014 thru December 8, 2016 | Nurse Practitioner |

## Medical Staff Additional Clinical Privileges

| | | |
|---|---|---|
| Corrigan, Eliona, MD | Mammography Interpretation | Radiology |

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## John H. Stroger, Jr. Hospital of Cook County (continued)

### Non-Medical Staff Additional Clinical Privileges

| | | |
|---|---|---|
| Martin, Kristine S., CNP<br>With Bell, Margo A., MD<br>Effective: | Pediatrics / Adolescent Medicine<br><br>December 9, 2014 thru August 25, 2015 | Nurse Practitioner |
| Micci, Sandra J, PA-C<br><br>Effective: | Medicine/Infection Disease<br>High Resolution Anoscopy and Biopsy<br>January 27, 2015 thru January 26, 2017 | Physician Assistant |
| Sarazine, Julia T., CNP<br>With Shariff, Ruhi R., MD<br>Effective: | Medicine / General Medicine<br><br>December 9, 2014 thru July 18, 2015 | Nurse Practitioner |

### Medical Staff Status Change With No Change in Privileges

| | | |
|---|---|---|
| Samuel, Macob, MD | Medicine/Pulmonary | Active To Voluntary |
| Knadra, Suhail, MD | Medicine/Cardiology | Active To Voluntary |

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ON DECEMBER 9, 2014

Anwer Hussain, DO, FAAEM
President,
Medical Executive Committee
Provident Hospital
Of Cook County

December 5, 2014

Dear Members of the Quality and Patient Safety Committee:

Please be advised that at the Credentials Meeting held on November 4, 2014 and December 2, 2014 the Medical Executive Committee of Provident Hospital of Cook County recommended the actions on the enclosed list. It is being presented to you for your consideration.

Respectfully,

Anwer Hussain, DO
President, MEC

# Provident Hospital of Cook County

**Medical Staff Action Items Subject to Approval by the CCHHS Quality and Patient Safety Committee**

## INITIAL APPLICATION

| | | |
|---|---|---|
| Garcia, Marlon Diaz, MD<br>Appointment Effective: | Internal Medicine<br>December 9, 2014 thru December 8, 2016 | Affiliate Physician |
| Kumssa, Admasu, MD<br>Appointment Effective: | Internal Medicine<br>December 9, 2014 thru December 8, 2016 | Affiliate Physician |
| Pierko, Kazysztof, MD<br>Appointment Effective: | Internal Medicine<br>December 9, 2014 thru December 8, 2016 | Affiliate Physician |
| Polyakova, Elina S, MD<br>Appointment Effective: | Internal Medicine<br>December 9, 2014 thru December 8, 2016 | Affiliate Physician |
| Reynolds, Albert, MD<br>Appointment Effective: | Internal Medicine<br>December 9, 2014 thru December 8, 2016 | Active Physician |
| Turbay, Rafael F., MD<br>Appointment Effective: | Internal Medicine<br>December 9, 2014 thru December 8, 2016 | Affiliate Physician |
| Yamani, Naser, MD<br>Appointment Effective: | Internal Medicine<br>December 9, 2014 thru December 8, 2016 | Affiliate Physician |

## REAPPOINTMENT APPLICATION

### Department of Internal Medicine

| | | |
|---|---|---|
| Hollandsworth, Don LeRoy, DO<br>Reappointment Effective: | Medicine<br>December 19, 2014 thru December 18, 2016 | Active Physician |

### Department of Obstetrics and Gynecology

| | | |
|---|---|---|
| Abrego, Fidel, MD<br>Reappointment Effective: | Obstetrics and Gynecology<br>January 18, 2014 thru January 17, 2016 | Active Physician |
| Fish, Karen, MD<br>Reappointment Effective: | Obstetrics and Gynecology<br>January 18, 2014 thru January 17, 2016 | Active Physician |

### Department of Surgery

| | | |
|---|---|---|
| Totonchi, Emil F.H., MD<br>Reappointment Effective: | Urology<br>December 18, 2014 thru December 17, 2016 | Active Physician |

## Renewal of Privileges for Non-Medical Staff

| | | |
|---|---|---|
| Matlock, Sharon, CNM<br>With Cash, Crystal D., MD<br>Effective: | Family Medicine<br><br>December 9, 2014 thru December 8, 2016 | Certified Nurse Midwife |
| Shah, Chandrika, H, PA-C<br>With Crawford, Clifford S., MD<br>Alternate Ansari, Shahid A., MD<br>With Totonchi, Emil F.H., MD<br>Alternate Beck, Traci P., MD<br>With Rafiq, Asad,MD<br>Alternate Johnson, Claudia M., MD<br>Effective: | Surgery/General Surgery<br><br><br>Surgery / Urology<br><br>Internal Medicine / Gastroenterology<br><br>December 9, 2014 thru December 8, 2016 | Physician Assistant |

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ON DECEMBER 9, 2014